[H.A.S.C. No. 110–152]

CHALLENGES ASSOCIATED WITH ACHIEVING FULL DENTAL READINESS IN THE RESERVE COMPONENT

HEARING

BEFORE THE

OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

HEARING HELD
APRIL 23, 2008

U.S. GOVERNMENT PRINTING OFFICE
43–787 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

VIC SNYDER, Arkansas, *Chairman*

JOHN SPRATT, South Carolina
LORETTA SANCHEZ, California
ELLEN O. TAUSCHER, California
ROBERT ANDREWS, New Jersey
SUSAN A. DAVIS, California
JIM COOPER, Tennessee
HANK JOHNSON, Georgia
JOE SESTAK, Pennsylvania

W. TODD AKIN, Missouri
ROSCOE G. BARTLETT, Maryland
WALTER B. JONES, North Carolina
JEFF MILLER, Florida
PHIL GINGREY, Georgia
K. MICHAEL CONAWAY, Texas
GEOFF DAVIS, Kentucky

SASHA ROGERS, *Research Assistant*
TOM HAWLEY, *Professional Staff Member*
MARK PARKER, *Staff Assistant*

CONTENTS

CHRONOLOGICAL LIST OF HEARINGS

2008

WEDNESDAY, APRIL 23, 2008

CHALLENGES ASSOCIATED WITH ACHIEVING FULL DENTAL READINESS IN THE RESERVE COMPONENT

STATEMENTS PRESENTED BY MEMBERS OF CONGRESS

WITNESSES

APPENDIX

CHALLENGES ASSOCIATED WITH ACHIEVING FULL DENTAL READINESS IN THE RESERVE COMPONENT

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE,
Washington, DC, Wednesday, April 23, 2008.

The subcommittee met, pursuant to call, at 2:28 p.m., in room 2212, Rayburn House Office Building, Hon. Vic Snyder (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE FROM ARKANSAS, CHAIRMAN, OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

Dr. SNYDER. The hearing will come to order.

Good afternoon. Welcome to the Subcommittee on Oversight Investigations hearing, the first hearing to discuss the challenges associated with achieving full dental readiness in the Guard and Reserve. And before proceeding with my opening statement, I want to acknowledge all of the work that the staff and the members did on our report on the Provincial Reconstruction Teams. I just went on the Web site for the House Armed Services Committee. It is on the Web site. So if anybody wants to read it, they can. There will be hard copies coming out later. It is armedservices.house.gov for those people that are interested.

The Reserve component is transforming from a strategic to an operational reserve. We need to give our men and women in the Guard and Reserve the tools they need to take up this mission. The most important thing they bring to the table is themselves, their health and the mental and dental readiness of the force. Oral health is an often overlooked, but as we are learning, extremely important aspect of overall pre-deployment readiness. The Department of Defense (DOD) has said that 95 percent of military personnel, active and Reserve, should fall into Class 1 or Class 2 dental fitness categories, meaning that they are healthy enough to deploy.

Right now none of the services are meeting these goals through the Reserve component, but the Army and Marine Corps have struggled the most. It is a public health issue for the country, but it is also a readiness issue for our military. Only 43.2 percent of the Army National Guard and 50.6 percent of the Army Reserve is currently ready to deploy. Only 77.7 percent of the Marine Corps Reserve is ready to deploy. But since none of the services are meeting the DOD goal, I hope we are going to figure out why today.

Today we will hear about some of the challenges the services face and how they are facing them. I hope we will hear some good ideas about how these issues can be addressed in the future. I know that the Army National Guard's 39th Infantry Brigade in my home dis-

trict in Arkansas struggle with many of these challenges when they recently deployed to Iraq for their second tour, and these challenges occurred during their first tour several years ago also. I am proud of their hard work and the creative ways in which they accomplished the pre-mobilization and readiness mission under adverse conditions, but they encountered additional challenges at the mobilization station, and we still have work to do.

Improving dental readiness rates in the Reserve component will require a combination of command emphasis, accountability on the part of the individual services, service members, incentives and possibly programmatic changes. That is why we are here. That is what we are here to talk about today, and I look forward to having a good discussion.

I also want to acknowledge the presence with us today of Congressman Buyer, who is the ranking member on the House Veterans' Affairs Committee, and he and I have talked about dental issues on and off for some time. And I would ask unanimous consent that he be allowed to participate. Now, I would like to hear Mr. Akin's opening statement for any comments he would like to make.

[The prepared statement of Dr. Snyder can be found in the Appendix on page 31.]

STATEMENT OF HON. W. TODD AKIN, A REPRESENTATIVE FROM MISSOURI, RANKING MEMBER, OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

Mr. AKIN. Thank you, Mr. Chairman.

Thank you witnesses for joining us here today.

The hearing clearly demonstrates the value of our subcommittee and the good we can do for our men and women in uniform. At first glance, dental readiness may not seem to be a subject Congress would focus on. And, in fact, I don't remember any previous hearings on the topic. Upon great reflection, though, all would conclude that the dental readiness is a very timely and critical topic. Armies throughout history have suffered more casualties from sickness than from combat-inflicted wounds, and today's military forces are no exception.

Indeed, medical and dental readiness are key components of ensuring units are ready to deploy and effectively perform their missions in combat. Our witnesses are well grounded in the challenges of ensuring members of the Army, Navy, Marine Corps and Air Force Reserve components are dentally ready to deploy and in the effectiveness of Department of Defense and individual service approaches to this issue. I would not want to be in their shoes. I cannot imagine a more difficult job than theirs, find ways to entice relatively juvenile Reserve component service members, most on limited income, to undergo periodic dental examination and treatment with sometimes minimal reimbursement so they can deploy to Iraq for 12 or 15 months.

Frankly, I am surprised that anyone goes to the dentist with a command tour in Iraq as a reward of compliance. In reviewing your testimony, I understand that each component faces somewhat different obstacles and has chosen to manage the problem in different ways. I look forward to hearing about your programs, any rec-

ommendations that you would have and how we in Congress can help to make your job easier. Thank you very much.

And thank you, Mr. Chairman.

[The prepared statement of Mr. Akin can be found in the Appendix on page 33.]

Dr. SNYDER. Thank you, Mr. Akin.

We are pleased to have with us today Colonel Gary Martin, United States Air Force, the chief of the Dental Care Branch of TRICARE management activity; Colonel Mark Bodenheim, the chief of the Reserve Component Mobilization and Demobilization Operations, U.S. Army Dental Command; Colonel David Sproat, the chief surgeon of the Army National Guard; Captain Kerry Krause, the Reserve Affairs Officer for the U.S. Navy Dental Corps; Colonel Deborah Hart, mobilization assistant to the Air Force assistant surgeon general for dental services, Office of the Surgeon General, United States Air Force.

It is my understanding that none of you have testified formally before Congress before; is that correct? Well, I want you to relax. You may feel a little pinch. You may hear some strange sounds and smell some funny smells, but ignore them. We are going to play some music for you to help you relax. I have always wanted to say that to dentists. This was my chance.

Now, we appreciate you all being here. Your written statements, without objection, will be made a part of the record, and I will have Sasha put on the light. When you see it go red, if you have got more things to tell us, we want you to go ahead. But it is just to give you an idea of when five minutes have gone by. We anticipate there will be votes some time in the next 10, 15, 20 minutes, which will interrupt us. But we will go as far as we can with opening statements.

So, Colonel Martin, we will begin with you.

STATEMENT OF COL. GARY C. MARTIN, USAF, CHIEF, DENTAL CARE BRANCH, TRICARE MANAGEMENT ACTIVITY

Colonel MARTIN. Thank you, Mr. Chairman, and distinguished members of the subcommittee. I thank you for your strong interest in improving the dental readiness of Reserve and National Guard service members.

As the chief of the Dental Care Branch of the TRICARE Management Activity, I am responsible for the management of the various Department of Defense dental programs that provide care to beneficiaries. Today I will provide a brief explanation of DOD's Oral Health and Readiness Classification System, discuss the current state of Reserve component dental readiness and give an overview of dental programs available to Reserve component members.

For over 24 years, DOD has successfully gauged the dental readiness of the active and Reserve components through the Oral Health and Readiness Classification System. The various classifications in this system are:

Dental Class 1, individuals with a current dental examination who do not require dental treatment or reevaluation, healthy service members who are worldwide deployable.

Dental Class 2, individuals with a current dental examination who have oral conditions, diseases that require non-urgent care or

reevaluation. These are oral conditions which are likely to result in a dental emergency within 12 months. These service members are also worldwide deployable.

Dental Class 3, individuals who require urgent or emergent dental treatment that if not accomplished will likely result in a dental emergency within 12 months. Class 3 individuals are not worldwide deployable.

And Dental Class 4, individuals who have not obtained periodic dental examinations or patients with an unknown dental classification. Class 4 individuals are not worldwide deployable.

Over the past 12 months, Individual Medical Readiness reports for the Reserve component have not shown any significant change. None of the services meet the DOD goal of 95 percent dental readiness. As of January 2008, the Army National Guard was at 43.2 percent; Army Reserve 50.6 percent; Marine Corps Reserve, 77.7 percent; Air Force Reserve, 84.9 percent; Air Force National Guard, 88.8 percent; and the Navy Reserve was 90.0 percent.

The majority of the Class 3 dental conditions in our service members are a result of dental decay, which is a chronic infectious disease. To properly treat and prevent dental decay, individuals at high risk for this disease must modify their diets and eating behaviors and practice good daily oral hygiene. If these measures are not taken, dental decay may recur, often resulting in more extensive treatment needs such as a larger filling, root canal, and/or a crown, and just a little pinch.

Several studies have validated the importance of DOD's Oral Health and Readiness Classification System. A published study by the Tri-Service Center for Oral Health showed that the dental emergency rate for Class 3 personnel is 8.8 times higher than personnel in Class 1 and 3.9 times higher than the rate in Class 2 personnel. A recent report on 900 Air Force personnel deployed for 120 days found that only 1.7 percent received any needed dental care during the deployment. Almost 65 percent of these personnel were dental Class 1 when deployed. If we deploy personnel in good oral health, their chances for a dental emergency during the deployment are significantly reduced.

There are several programs available to improve the dental health of the Reserve component members. I would like to highlight those programs for you today. For Reserve component members without employee-sponsored dental insurance, DOD offers the TRICARE Dental Program (TDP), a comprehensive dental insurance program for active duty family members, Reserve component members and their families. Over the past 2 years about 8 to 10 percent of eligible Reserve members have enrolled in this program. The Air Guard has the highest enrollment with 21.8 percent. The lowest enrollment rate is in the Marine Corps Reserve at only 2.8 percent. The government pays 60 percent of the monthly premium, and the reservist pays 40 percent. Currently the reservist pays a low monthly premium of $11.58. The TDP provides an annual maximum payment for dental services of $1,200 with cost shares for the more expensive procedures, such as root canals, crowns and extractions. Most preventive services, like cleanings and exams, are covered at 100 percent and do not count toward the annual maximum payment.

For Fiscal Year 2007, 71.6 percent of the reservists enrolled in the TRICARE Dental Program utilized at least one covered procedure. The TDP network of dentists is quite large with over 84,434 participating dental offices. This includes 63,555 general dentist locations and 20,769 specialist locations.

In addition, the Reserve Health Readiness Program provides dental care for reservists. This program has a network of contracted dentists that provide dental exams and Class 3 treatment needs to assist reservists in achieving and maintaining dental readiness. During the past 12 months, approximately 180,000 reservists received their annual dental exam and 7,500 Class 3 patients received the required dental care in this program; 92 percent of the reservists who received their exams and treatments were Army.

Reservists on 90-day activation orders are eligible for dental care at the same level as active duty service members. The majority of this dental care is provided in military dental treatment facilities, when needed. Referrals are also made to dentists in the private sector.

The Transitional Assistance Management Program, commonly referred to as TAMP, includes a dental benefit for recently deactivated or separated military members. This program provides space-available care in military dental treatment facilities for 180 days from the date of leaving active duty status. Unfortunately, few facilities have space available to treat these members. But reservists who are deactivated and who will remain in the Reserves are eligible to enroll in the TRICARE Dental Program.

Finally, all service members who are separated from active duty receive a certificate of release or discharge from active duty. A section of this form documents whether there are any dental conditions requiring treatment that DOD could not provide prior to separation. If treatment is required, the member may apply for Veterans Affairs (VA) treatment within 180 days from release from active duty. On average, about 18 percent of eligible deactivated reservists have utilized this benefit over the past 3 years.

Mr. Chairman, distinguished subcommittee members, thank you for your interest in improving the dental readiness of our National Guard members and reservists. As you can see, the department offers several options to improve the dental readiness of these service members. We look forward to your continued support as we work together to improve the oral health of Reserve component members. I will be happy to answer any questions that you may have.

[The prepared statement of Colonel Martin can be found in the Appendix on page 34.]

Dr. SNYDER. Thank you, Colonel Martin.

Colonel Bodenheim.

STATEMENT OF COL. MARK BODENHEIM, USA, CHIEF, RESERVE COMPONENT MOBILIZATION AND DEMOBILIZATION OPERATIONS, U.S. ARMY DENTAL COMMAND

Colonel BODENHEIM. Yes, Mr. Chairman and distinguished members of the committee, I want to thank you for allowing me to speak to you about Army Reserve component dental readiness.

In my written testimony, I have outlined an extensive historical perspective of dental readiness for the Army active and Army Reserve components. To summarize, by the first Gulf War, active component units were able to deploy with minimal pre-deployment dentistry requirements due to their high levels of baseline dental readiness, while at the same time Army Reserve component units arrived at extremely high rates of unreadiness. This happened again at the beginning of the global war on terror.

Since 2004, the Army active and Reserve component dental subject matter experts have cooperated to improve dental readiness report rates to the mobilization platforms by standardizing exam protocols and documentation, the validation process at the mobilization platform and storage of digitized dental information for further use. These improvements have reduced no-go rates to the mobilization platforms from 87 percent no-go in 2004 to the present rates that you see in table one in Fiscal Year 2006 and 2007.

During the first half of Fiscal Year 2008, more dramatic improvements occurred, especially by the Army National Guard brigade combat teams (BCTs). And I attribute these improvements in dental readiness due to a combination of, first, Army command emphasis directed to the BCT commanders, initiation of the Reserve component dental readiness systems early in the alert phase, and diligent work done by the State dental surgeon.

In table two, you can see, of my written testimony, you can see a comparison on the BCT units and smaller size units. And you can see that the smaller size units report with less favorable rates of dental readiness. And I attribute this to less command emphasis and a larger percent of cross-leveling from non-alerted units that are not eligible for Dental Fitness Class 3 (DFC 3) care. As an example, over 6 percent of the 39th BCT was cross-leveled as replacement soldiers after reporting to Camp Shelby after the main body had reported, and over 26 percent of those were DFC 3. I use this example to point out a major issue. Army Reserve component soldiers may be mobilized with short notice at any time. And if not afforded DFC 3 care, regardless of alert status, prior to mobilization, then they lose training time at the mobilization platform remedying those DFC 3 conditions.

For the first half of Fiscal Year 2008, it is estimated that over 3,500 10-hour duty days had been lost remedying DFC 3 conditions of mobilization platforms. In my written testimony, I have described a present mobilization and demobilization operating procedures, and I will refer you there for the details of those operations in their present format. In my written testimony, I have described the challenges to achieving better Army Reserve component dental readiness. And suffice it to say, the challenges are complex and will require a multiple set or dashboard of solutions.

Within his first 100 days, the Army surgeon general directed a complete review of the Army Reserve component dental readiness system, and the assistant surgeon general for forced projection assembled a multicomponent work group in March 2008 to conduct a capabilities-based assessment and develop a prioritized list of courses of action. These courses of action are currently being worked through the Army leadership.

In conclusion, I want to thank you, Mr. Chairman, and the distinguished members of the subcommittee for your interest and support in improving Army Reserve component dental readiness and in maintaining our human weapon system, our soldiers.

Thank you.

[The prepared statement of Colonel Bodenheim can be found in the Appendix on page 39.]

Dr. SNYDER. Thank you, Colonel.

Colonel Sproat.

STATEMENT OF COL. DAVID SPROAT, USA, CHIEF SURGEON, ARMY NATIONAL GUARD

Colonel SPROAT. Chairman Snyder, Ranking Member Akin, distinguished members of the committee, thank you for this opportunity to come before you to address concerns of the dental readiness of the soldiers of the Army National Guard.

Dental readiness of our citizen soldiers is a critical element in our ability to meet Army deployment requirements. As you know, the Army National Guard's transition to an operational force has dramatically increased demands on your citizen soldiers. Historically, our soldiers and leaders relied on a lengthy mobilization process to address dental readiness issues.

In February 2007, the Department of Defense implemented a 12-month mobilization policy. This policy is good for the Guard and takes soldiers away from their families and employers for less time. However, dental readiness must now be addressed at the home station.

The Army National Guard medical team in conjunction with our U.S. Army Dental Command colleagues has successfully managed this transition. Since the beginning of the fiscal year, States have prepared 5 brigade combat teams for deployment, sending their units to the mobilization (MOB) station over 90 percent dentally ready. For example, the 39th from Arkansas arrived at Camp Shelby in January with 92 percent of their soldiers dentally ready. This is a tremendous improvement from their last mobilization in October 2003, when the average readiness of a Guard unit reporting to MOB station was 13 percent. This improvement has enabled commanders to focus on collective training and maximize the boots-on-ground time in theater.

To ensure mission success, this same approach is being used this year by Pennsylvania's 56th Striker BCT and 28th Combat Aviation Brigade, New Jersey's 50th infantry BCT, North Carolina's 30th Heavy BCT and the 56th/36th Infantry BCT from Texas. The same programs, policies and procedures that have been used to ready these BCTs for deployment need to be applied to our force as a whole.

The challenge before the Army National Guard is the low level of baseline dental readiness. Only 43 percent of the force is dentally ready to deploy. Few Army National Guard guardsmen have private dental insurance, and only seven percent participate in the TRICARE Reserve Dental Program. Truly Herculean efforts must be applied by the states once a unit is alerted to achieve full dental readiness.

To overcome these challenges, the Army National Guard in collaboration with the Office of the Surgeon General, U.S. Army Dental Command, the U.S. Army Reserve has developed a plan to improve baseline readiness that has been approved by the Army Guard leadership. This plan provides dental treatment for our soldiers outside of alert. Under the Army Selected Reserve Dental Readiness System, or ASDRS, states can provide dental treatment to soldiers through local contracts or the Tri-Service Reserve Health Readiness Program, or RHRP. The U.S. Army Dental Command's First Term Dental Readiness Program will identify dental issues that must be corrected and ASDRS will then enable our soldiers to be treated at home.

As recommended by the commission on the National Guard and Reserve, there should be incentives and enforcement of dental readiness. Guardsmen should not take unpaid leave to go to the dentist. Providing two medical readiness days per soldier is an incentive for soldiers to complete readiness requirements and a way for commanders to ensure compliance. The Unit Status Report and the Medical Protection System or MEDPROS provides leaders with the ability to track a unit's dental readiness.

Increasing and sustaining dental readiness of the Guard requires appropriate staffing. The Army National Guard Dental Corps is currently less than 60 percent strength, and 40 percent of those remaining dentists are retirement eligible. The Department of Defense has requested that Congress increase the retirement age of National Guard Medical Corps and Dental Corps officers from 64 to 68. The President's budget request now before Congress also seeks an increase in the level of full-time manning of our force. This is critical. We urge the Congress to support these proposals.

This is a very exciting time to be in the Guard. The Army National Guard has deployed over 300,000 dentally ready soldiers in support of the Nation since September 11, 2001. Even so, we can do better. The Army National Guard is committed to improving our dental readiness. I am grateful for this opportunity to appear before the subcommittee and look forward to answering your questions.

[The prepared statement of Colonel Sproat can be found in the Appendix on page 53.]

Dr. SNYDER. Thank you, Colonel.

Captain Krause.

STATEMENT OF CAPT. KERRY J. KRAUSE, USN, RESERVE AFFAIRS OFFICER, U.S. NAVY DENTAL CORPS

Captain KRAUSE. Chairman Snyder, distinguished members of the committee, good afternoon and thank you for this opportunity to present to you today about the Navy's mission, that of ensuring dental readiness for all its Marines and sailors, both Reserve and active. Dental readiness is a state where a sailor or Marine is ready to deploy and likely not to experience a dental emergency while away from home.

When a recruit is assessed, an initial exam is performed, and he or she is classified according to his or her dental disease. Annual exams are required for both Reserve and active component sailors and Marines. It is a triage system that prioritizes care based on

the level of disease. A sailor or Marine is operationally dentally ready, ODR, if he or she falls into either Class 1, no disease, or Class 2, diseases unlikely to cause a dental emergency within 12 months.

The goal, as stated by the Office of the Secretary of Defense for Health Affairs is for all services to reach 95 percent ODR. There is currently no Navy-specific mandate. Over the past 3 years, incoming Navy and Marine Corps recruits have entered boot camp at an average ODR of 29 percent. At the Navy and Marine Corps boot camps, Navy dentistry has maintained a heavy dental presence that focuses on reaching the 95 percent goal before our recruits go back to Reserve status or reach their duty stations. While we have fallen short of the 95 percent goal in the last few years, we have maintained an ODR in the 80th percentile.

Historically through 2002, ODR percentage across the Navy has been in the mid 90's or above. Since 2002, however, it has fallen to 86, 87 percent as we shift resources to focus on personnel who are getting ready to deploy. For the Navy Reserve, of the 16,193 service members who are still drilling and have mobilized, they were 91 percent operationally dentally ready, with 1.5 being considered Class 3.

For the Navy's active component, the last 112 shifts that have deployed have all had an ODR above 95 percent. Over the first quarter of Fiscal Year 2008, the overall ODR for the Marine Corps Reserve was 77.7 percent with 6.5 percent being considered Class 3. Our efforts to focus on deploying Marines and reservists have paid off, and the last two battalions to deploy in 2007 went out at greater than 95 percent ODR. Active duty Marine units deployed at 90 to 97 percent ODR.

The Reserve challenges to ODR include dental officer and technician retention and recruiting and the loss of 17 percent of the Reserve Dental Corps billets. As the Navy Reserve Dental Corps becomes smaller, providing regular exams has become a challenge. We are meeting this challenge by using contract dentists, offering more incentives to retain and recruit, hosting dental stand downs for units to get exams all at one time and having traveling dental teams to go to remote locations.

In addition, there is a perception by reservists that the cost of the TRICARE Dental Program, $11.58 a month plus 20 percent cost share for fillings, is prohibitive. We are addressing this issue by increasing our education efforts for reservists on the value of this program.

To maintain our ODR goals with decreased Reserve and Active Dental Corps personnel, we have increased the use of private-sector dentists through the Military and Medical Support Office Program, MMSO. This shift in care of the private sector has increased the MMSO costs over the past 4 years from $3.7 million in 2004 to $34 million in 2007. Retaining Dental Corps Officers in Reserve and active components has been increasingly difficult in recent years. Almost 70 percent of junior officers are leaving active duty after they complete their first obligated tour and are not affiliated with the active Reserve. One of the major issues has been dental assistant support, which is now beginning to improve. Another motivator for getting out of the service has been the rates of promotion and pay

for Dental Corps officers. Promotion issues are improving, and we are hopeful the trend will be maintained. In addition, recent improvements by the National Defense Authorization Act increased additional special pay, ASP, for junior dental officers by $6,000 to $10,000 or $12,000 based on years of service. We expect this increase in the ASP will have a positive impact on retention. Today, with this increased pay, an active duty dentist in Washington, D.C., with 4 years of experience earns about $95,000 plus benefits.

Improvements to Dental Corps accession bonuses for Reserve and active duty and stipends for Reserve scholarship programs have recently improved, and we thank you for your support. We are optimistic these enhancements have improved our recruitment efforts, as we at this point in the fiscal year expect to meet our accession goals. Currently, we are almost 100 percent ahead of where we were at this time last year. In the Reserve corps, we have already gained 14 new dental officers compared with 2 in Fiscal Year 2007.

Chairman Snyder, members of the committee, thank you again for the opportunity to testify before you and share with you how Navy dentistry is ensuring sailors' and Marines' dental readiness is our number-one priority. We appreciate your efforts to improve our recruitment and retention, as well as your interests in this very important issue. I stand prepared to answer any of your questions.

Thank you.

[The prepared statement of Captain Krause can be found in the Appendix on page 58.]

Dr. SNYDER. Thank you, Captain.

Those were votes. But we have plenty of time to do your opening statement, Colonel Hart, and probably get at least one question or two in. So, Colonel Hart.

STATEMENT OF COL. DEBORAH L. HART, USAF, MOBILIZATION ASSISTANT TO THE AIR FORCE ASSISTANT SURGEON GENERAL FOR DENTAL SERVICES, OFFICE OF THE SURGEON GENERAL, U.S. AIR FORCE

Colonel HART. Mr. Chairman and esteemed members of the committee, I appreciate the opportunity to appear before you today to discuss the dental readiness of the Air National Guard and Air Force Reserve.

The ARC or Air Reserve Component Medical and Dental Services exist and operate within an Air Force culture of accountability where medics work directly for the line of the Air Force. Our home station facilities form the foundation from which the ARC provides combatant commanders a fit and healthy force. Our emphasis is on fitness, prevention, and surveillance so that we can be ready to be deployed if need be in less than 72 hours.

Air Guard and Reserve dental readiness is at 89 and 86 percent, respectively. These statistics represent a steady upward trend over the past year and compare favorably to the Department of Defense goal of 95 percent. Our steadily improving dental readiness is attributable to many factors.

First and foremost is command emphasis and support at all levels. The ARC holds unit commanders and individual service mem-

bers responsible for the members' readiness to deploy and provides policies to ensure dental readiness.

We have several methods an ARC member can receive their annual dental exam: by a military dentist, a civilian or TRICARE Dental Plan participating dentist, or by contractor dentists through the Reserve Health Readiness Program.

Although medical squadrons track dental readiness rates, each ARC unit also has a nonmedical unit health monitor who tracks upcoming and overdue medical and dental needs. This creates ownership of medical readiness within the unit itself and has had an extremely positive effect on our readiness.

ARC compliance policies may be the most effective of our tools to steadily improve readiness. Air reservist or guardsmen in dental Class 3, requiring urgent or emergent dental treatment, are placed on a medical profile and cannot have orders cut to deploy while profiled. Members are given a limited time frame to correct their dental deficiencies. Failure to have the required treatment can lead from profiling to administrative discharge of the member.

Commanders do have the authority to grant a waiver to allow deployment of a member in dental Class 3, but this is extremely rare. All ARC units have regular health service inspections, and units with deficient programs are identified to line commanders, who are held accountable for the medical and dental readiness of their units.

Another tenet of our success has been the full alignment with the active duty Air Force Dental Service in using the same Web-based reporting and tracking tool, the Dental Data System Web, or DDSW.

Some challenges do remain for the ARC to be able to steadily improve our dental readiness, but the cost of meeting standards can sometimes be prohibitive, especially for the lower-ranking enlisted personnel. Even with TRICARE Dental Plan available, many U.S. areas have limited networks of dental providers. Furthermore, due to time constraints and rigors of basic military training and technical school, access to new accessions for dental treatment is very limited and usually consists of palliative care for urgent needs.

Currently, there is no Transitional Assistance Management Program, or TAMP, available for dental care following deployment. And although the ARC and the active duty Air Force units use the same Web-based reporting tool, we are not yet set up to implement the electronic dental record, or AHLTA, which will surely improve accuracy of readiness as reservists and guardsmen transition from inactive to active status and back again.

To improve dental readiness, Reserve and Guard units can utilize dentists from other units for support. Higher headquarters monitors readiness statistics, conducts site visits and provides assistance where needed. Geographically separated, remote or understaffed units can utilize contractor-supported dental exams.

Increased emphasis by commanders and unit health monitors and recruiters to inform Reserve and Guard members of the benefits presently provided under the Reserve Health Readiness Program may also improve readiness. We are also considering the introduction of a pre-accession dental screening exam to determine the dental class of an individual, which could help alleviate the

problem of ARC members arriving on base, non-deployable, Dental Class 3, after completion of basic and technical training.

Last, we fully support implementing the electronic dental record in the ARC as it becomes available for deployment.

In closing, Mr. Chairman, we are proud of our accomplishments and continued improvement of the Air Force Reserve and Air National Guard dental readiness rates. We thank you and the members of your subcommittee for your interest and support and look forward to your help in continuing that improvement. Thank you.

[The prepared statement of Colonel Hart can be found in the Appendix on page 62.]

Dr. SNYDER. Thank you.

Sasha will go ahead and put me on the five-minute clock here, and we will go through our five-minute rule here.

The noise you heard there was we have one vote, perhaps followed by a series of votes. It is not clear yet. So we will have to take a break here probably after my questions. But we should have time to get in my five minutes.

I wanted to say, first of all, I appreciated your, both written and oral, statements. It is not, as one pointed out, it is not a simple challenge that you have before you. And, of course, in some ways, the challenge you have reflects the fact that we as a Nation haven't solved a lot of health care issues, including dental. So you are ending up with a representative sample of our population that doesn't have the kind of dental health we need.

I think some people when they heard about this thought that somehow this is a bit of a trivial problem. But, I mean, just for emphasis, the whole purpose of this is to avoid dental emergencies for people you are sending to a war zone for 7, 12 or 15 months. And I can't imagine being in the mountains of Afghanistan or some place in Iraq with a big dental abscess, trying to figure out how I am going to get that resolved, get it treated. Not to mention you then are pulling someone away from their unit and causing a disruption of their unit.

And then, as a couple of you pointed out, the second issue is if you have to deal with this during the pre-mobilization period, which is—or the pre-deployment period, we talked about the 3,500 10-hour days lost or the 5,000 10-hour days lost. We call them due dates, but for most people, they are training days. That means they are being pulled away from training for a war zone.

And then the third part, I guess, is quality of life. I can't imagine sending somebody over there and cavalierly saying, well, you have got a big hole in your mouth, but we don't have time to do that right now, tough it up for 12 months. I mean, that is not the kind of country—we have learned that that is short-sighted.

So this is a very important issue in terms of accomplishing the kind of goals we want for our national security and foreign policy.

Colonel Bodenheim, you, on page 10, of your written statement, you make the comment there, we need to enforce current policy. Now, several of you have called for different changes. Talk to me about that. Is there a way—if we made no changes at all—to solve this problem just by enforcing current policy? Or is that an unrealistic goal?

Colonel BODENHEIM. Current policy allows for an annual exam regardless of alert status. But if a soldier is found to be DFC 3, Dental Fitness Class 3, during that exam and they are not in an alert status, they have no way of getting that care done at no cost to themselves. And so it does not solve the problem for the large group of un-alerted mobilized Reserve—of nonmobilized Reserve but not alerted, and the large number of cross-leveling that goes on is causing that loss of training time at the mobilization platforms. And that is unpredictable, and the only way to solve that is to have the care system that is there all the time, regardless of the alert status.

Dr. SNYDER. Captain Krause, you discussed the boot camp issue, that, I believe, the number of 80 percent in boot camp. Now, is that correct currently?

Captain KRAUSE. When they come in, they come in at 29 percent.

Dr. SNYDER. And when they leave, currently about 80 percent?

Captain KRAUSE. That is correct, 80 percent.

Dr. SNYDER. That would seem to me, recalling my boot camp days, when I couldn't go to the bathroom without somebody ordering me to, you have got a captive audience there. Why is that only 80 percent? These are not people that are going to be pulled away for deployments. I mean, you have got them there for probably three months. Why has that been a difficult—why are we missing one out of five of those people?

Captain KRAUSE. Well, thank you, chairman. Let me say this. It is probably more like 86 percent, and that is on the active side. Again, they have a lot of things that they have to accomplish in the boot camp, and they are busy, and they don't have a lot of time for dental. And we try to fit them in and get as much done as we can when we can. It is not that they are free to come to dental at any time during their training. They basically are busy. That is why they are there, to learn. The dental piece of it is—we push it as they come in from the day they come in, and we do it as much as we can as we can.

Dr. SNYDER. Well, we will pursue that later. My time has expired. What we will do is recess for the votes. I am sorry. I can't predict how long this will be. We have several staff members that can help you with any phone needs you have or if you need a private room or something. And we also have other staff, we have Jeanette James and David Kildee from Personnel Subcommittee. We have Art Wu here from the Veterans' Affairs Committee. They may have some questions to pick your brain while we are doing recess. We will be recessed.

[Recess.]

Dr. SNYDER. We will go ahead and resume. I think that we are okay. We have already kept you almost into supper time, but I think that we are okay for a while now. Unfortunately, our members, for a hearing that started at 2:30, I figure after 4:30 they could have other things; so we will probably not have as good a response as we did early on, but I apologize for that.

And as soon as he is ready, we will recognize Mr. Akin.

Mr. AKIN. Just one second.

Dr. SNYDER. Sure.

Mr. AKIN. I certainly appreciate your all waiting around for quite a while. We have that happen in committees. All of a sudden they call votes, and we are not always sure when they are going to do it. So it does tend to break things up.

I guess my question, and one that we have been talking about a little bit, is the transition of whose responsibility is what? So I am thinking about somebody that is—let's say they are on Reserve for some particular moment, and as they are on Reserve, I would guess that Reserve people, their dental care is paid for out of their own pocket. Is that typically the case?

This is somebody that is going to be called up and then he is going to serve, so if you start at the beginning, when they are on Reserve, who pays for the dental care when he is just on Reserve? Anybody want to answer the question?

Colonel MARTIN. I will start with if the individual is enrolled in the TRICARE dental program, then certain procedures like an exam and a cleaning will be covered by that dental plan, and they will not pay for any of that process.

Mr. AKIN. So a Reserve, somebody who is on Reserve, could have that insurance?

Colonel MARTIN. Yes, sir.

Mr. AKIN. Okay. If they didn't have that, then they would normally just pay for it out of their own pocket?

Colonel MARTIN. Yes, sir.

Mr. AKIN. Then they get called up. And let's say if they were not paying attention to their teeth, they are young and bullet-proof or something like that, if you took that scenario, then you would give them a dental exam probably when they came in. And then, let's say, for instance, they might have a cavity or two or something like that.

So that would mean—would that be like Level 3?

Colonel MARTIN. Yes, sir.

Mr. AKIN. Okay. So then you would send them to a dentist, and it might be, say, an Air Force or an Army dentist or something like that; or it might be somebody that you contract with, either which way. Would that be what would probably happen next?

Colonel MARTIN. Yes, sir.

Mr. AKIN. And you would try to fit that in in their training as they are getting ready to be deployed or something like that. Is that typically when that would happen?

Colonel MARTIN. I think, for the majority of times, that would be correct, that when they get ready to be mobilized, different assets will come into play as far as to take care of their dental needs.

Mr. AKIN. I am just thinking, my own son is a captain in the Marines, and as I recall, before he was deployed they always had—sort of everybody was working up and getting used to working together. So that would be the time probably they would get the dental care, which would bring them up to a Level 1 or 2 or something like that, right?

Colonel MARTIN. Yes.

Mr. AKIN. And then they are deployed for some number of months, right?

Now, during the time that they are actually called up then, in a way, financially that is the responsibility of the service that has called them up. Is that right?

Colonel MARTIN. That is correct, sir.

Mr. AKIN. Okay. And then when, let's say, they have been in Iraq for a year or 14 months or something like that and they come back, now at that point if they had something going on, let's say got some cavities because they drank too much Coke over in Iraq or something like that, then whose responsibility would it be to provide that dental care?

Would that still be the active force or would that come out of DOD?

Colonel MARTIN. I would need to go back a little bit. It really depends upon their status in Defense Enrollment Eligibility Reporting System (DEERS). If they are still on active duty status, then all their dental needs are going to be taken care of by the active duty benefit which—most of us can be taken care of inside of our military dental treatment facilities.

Once they leave active duty status——

Mr. AKIN. Once they were deployed, if they were Reserve and they were deployed, wouldn't they be called active duty then?

Colonel MARTIN. Yes, they would.

Mr. AKIN. Because—I am kind of confused because I have run into people that, you know, they are sort of halfway active and halfway citizen, and I can't keep all the conditions straight.

Okay, so—but if they are deployed, they are active duty then, then they would be the responsibility of whichever branch they were in?

Colonel MARTIN. Yes, sir.

Mr. AKIN. Or maybe would you—would at times an Army guy go to a Air Force dentist or whatever?

Colonel MARTIN. Yes.

Mr. AKIN. Whatever the logical, close dental facility depending upon their situation, up to the time when they are no longer active or they are going back, probably to their Reserve unit, I would assume. So up to that day they are still the regular military.

And then when they go back to the Reserve unit, then would that mean that they would go back to either that insurance policy they had or they would just pay for their own dental care themselves?

Colonel MARTIN. Yes, sir. But there is also a benefit—if they serve for more than 90 days, there is also a VA benefit that they can also receive.

Mr. AKIN. So let's take our scenario they have been in Iraq for a year or something. Then they have been over 90 days, so then they would qualify; they wouldn't pay for everything out of their own pocket, it would be under the VA care then?

Colonel MARTIN. That is correct. If their discharge papers say all their dental care was not completed prior to discharge, they could take that paperwork and submit it to the VA.

The VA then would notify them of their eligibility. And then they can get that treatment taken care of at no cost to them.

Mr. AKIN. I am sorry, I am running over my time.

Dr. SNYDER. That is okay.

Mr. AKIN. Do they typically have a dental exam when they come back? Or is that something they could request?

Colonel MARTIN. I think, sir, it depends upon the——

Mr. AKIN. The unit?

Colonel MARTIN [continuing]. The units. And I would have to defer to the services to be able to answer that specific question.

Mr. AKIN. Does anybody know if it is policy one way or the other?

Colonel BODENHEIM. This is Colonel Bodenheim.

No exam is given during the demobilization process with our current policy.

Mr. AKIN. Say that again.

Colonel BODENHEIM. No exam is given during the demobilization process with our current policy. If somebody comes back and they say that they have an emergency situation, they are treated by that dental treatment facility before they are REFRAD, or released from active duty. The demobilization period is about a four-to-six-day period. And in the demobilization process at this time there are about one or two hours for a unit to be processed through the dental administrative process for demobilization.

Mr. AKIN. So, from a practical point of view, let's say I come back and let's say I have had a tooth that has been bothering me; I don't know what is going on with it.

Just maybe a regular soldier, would they probably then be looked at and given an exam and then a determination—say he had some cavities from drinking my Coke too much. Would you actually pick that up then?

Colonel BODENHEIM. Sir, what we would do is, if the soldier said that they had a condition that was causing them an emergency problem at that time, we would fix the emergent condition.

Mr. AKIN. Would that mean—I am just saying, you have a cavity; maybe it is not an emergency, your tooth is just sore or you suspect there may be a problem. Would that be an emergency per se or not?

Colonel BODENHEIM. That would not be an emergency.

Mr. AKIN. It would not?

Colonel BODENHEIM. Yes.

Mr. AKIN. So they might have some cavities and probably they would not be taken care of then until they actually were out. Is that probably what would happen?

Colonel BODENHEIM. That is correct, sir.

Mr. AKIN. Okay. So—but it is a fairly clear line if they get medical or dental care while they are on active, then it is an active duty responsibility. As soon as they are out, then—okay.

When they usually come back, though, on Reserve, isn't it a pretty short period of time when they actually get back in country and they are released? Is that pretty quickly, just like a week or so?

Colonel BODENHEIM. Yes, sir. It is a four-to-six-day demobilization period.

Mr. AKIN. Right. Okay.

Well, I think—I will do a follow-up.

Thank you, Mr. Chairman.

Dr. SNYDER. Mr. Buyer for five minutes.

Mr. BUYER. Thank you.

Colonel Bodenheim, when I came to San Antonio and you and three other officers testified with regard to this—I don't know what you call it, the Army Dental Care System Overview Support?

Now that you have had an opportunity to reflect and you have also given testimony to Art Wu several times, upon your reflection, is it fair to say that you knew the numbers were not fair and accurate as they were testified to me when I was in San Antonio?

Colonel BODENHEIM. Sir, is this concerning the demobilization——

Mr. BUYER. Yes.

Colonel BODENHEIM [continuing]. Process for the 1st through the 34th?

Mr. BUYER. Yes.

Colonel BODENHEIM. Sir, my personal opinion is that the numbers are not—not incorrect; they are just a different way of looking at how the costs for that process were arrived at.

Mr. BUYER. So is it fair to say that you were then following orders in that you were to make this program as costly as possible?

Colonel BODENHEIM. That is incorrect, sir. There were other courses of action that were actually more expensive.

Mr. BUYER. So you, though, presented to me a study that said that a dental exam and radiographs, if you were to do it at demobilization, would be $307, which is at the 95th percentile times 100 for the country.

Now, you can play wordsmith all you like, because others have already gone back in and looked at this and said, yes, these are bad numbers. Now, I am not your commander, so I am going to be straight up with you, because if I were your commander, I would prefer charges against three field grade officers and one general officer in the Army Dental Corps. I would.

Fraud is a very serious charge. Another serious charge is called "the intent to deceive."

You see, what you guys didn't know down there in San Antonio, what you do know now, is that this study was something that was created by the Surgeon General, Kiley then, and myself. So what you did in your little gamesmanship down there to sort of protect your idea of, Oh, we will do the contracting; at the same time we will utilize the VA.

You guys really messed up. You really have messed up bad.

Now, what hurts, what hurts the most is, soldiers aren't getting taken care of. Now, from the Army's point of view—perhaps the Army now has this perspective, because you made it very clear to me when you said—not you, but it was Colonel Hanson, with General Czerw sitting right next to him, who looked me in the eye, saying, upon demobilization, "not our mission." Said in such a strong, forceful, and yet almost arrogant tone, "not our mission."

Okay. That is why I have had some conversations here with the chairman of this committee, because we in the VA then become your bill payer. The purpose here is really for Army to take care of Army.

Now, when I look at this statement, I have been around long enough to know this statement is very poor that you have given—the written statement is very poor, because what is missing here, Colonel, somebody has scrubbed this thing. Whether it was

scrubbed through the Surgeon General's Office or through OSD or the Office of Management and Budget (OMB), it is really scrubbed.

Oh, I get the wordspeak at the end about solution sets and initiatives. That doesn't tell me anything. I also see where you embrace the existing provider contracts. I suppose that tells me that you really embrace Logistics Health Incorporated (LHI). Would that be accurate? The Dental Corps—you want to really embrace the LHI contract? Is that accurate?

Colonel BODENHEIM. Sir, I, personally speaking, I don't care what contractor is used to ensure dental readiness for our Army Reserve and Army Guard soldiers.

Mr. BUYER. Who should be providing that dental care, Colonel?

Colonel BODENHEIM. It should be a multifactorial situation. First of all, for the active component, when soldiers are coming into basic training——

Mr. BUYER. On demobilization (demob).

Colonel BODENHEIM. On demob, we should be able to provide it, as much as we can, within the four-to-six-day period. But again, Dental Command (DENCOM) does not determine what goes on in those four to six days.

Mr. BUYER. Does DENCOM still embrace "not our mission"?

Colonel BODENHEIM. We believe it is our mission——

Mr. BUYER. So your testimony now has changed. Why has it changed?

Colonel BODENHEIM. Personally speaking, it has changed because we think it is the right thing to do in order to reset the entire force and to improve the dental readiness of both components.

Mr. BUYER. All right. Then I suppose, personally, upon your reflection there at the moment, you recognized that what was done here was wrong.

I will ask for further questions with regard to the reset, because it is 1 year plus 90 days.

Dr. SNYDER. We will go around again, Mr. Buyer.

Colonel Sproat, I wanted to ask you on the first page of your written statement, and you mentioned it in your oral statement, you refer to the 39th and you say, "To ensure mission success, the same processes and techniques are being used this year," and you list some other units.

Give us a list, what do you consider to be the processes and techniques that the 39th used that you think should be used elsewhere or are being used elsewhere? Specifically, what are those processes and techniques?

Colonel SPROAT. Yes, sir.

Each of our states is unique in terms of their makeup, in terms of their geography, in terms of their dispersion of guardsmen. And so there is really no one set solution that we can apply to the Nation. We depend on the states to develop courses of action for each of their populations to be able to get these units ready.

There is a whole group of contract vehicles that are available to them, organic personnel to the unit that can be utilized to get those folks ready. We at the National Guard Bureau basically collect the best practices from each of these BCTs as they go through this process and then make sure that we learn as an organization how to do this best.

Dr. SNYDER. What are those best practices?

Colonel SPROAT. The best practices are early identification of the soldiers. Upon alert, making sure that every soldier has had an exam. Ideally, they have had that exam before alert. And then using the authority and the funding that we have to provide dental treatment for those soldiers during that alert phase, long before they go to the mobilization station.

The goal is that units should not train soldiers that are not medically deployable, so that basically we don't invest in them in training if they end up being medically nondeployable in the end state.

Dr. SNYDER. Colonel Martin, the TRICARE benefit is essentially what, it is about $11-or-so a month, and then the maximum amount that can be paid is $1,200. Is that correct?

Colonel MARTIN. Yes, sir. Yes, Mr. Chairman.

Dr. SNYDER. So you are investing $130 or $140 to offset the possible expense of $1,200. Is that a fair way of looking at it?

Colonel MARTIN. Mr. Chairman, it is pretty fair, but there is also the part that I want to note is for preventive care; that doesn't count toward that $1,200.

Dr. SNYDER. That's right.

Colonel MARTIN. So it is a little bit higher amount of benefit that you get for that amount of money.

Dr. SNYDER. And how do you—it seems like there are two issues. One issue is, why haven't more people taken advantage of that? The second issue is, even if somebody has insurance, a lot of people don't like going to the dentist.

Now, how do you think both those issues ought to be addressed?

Colonel MARTIN. Yes, Mr. Chairman.

The first is that, in my written testimony, it was 8 to 10 percent are currently enrolled in the program.

Dr. SNYDER. Very low.

Colonel MARTIN. It is very low. There have been certain surveys, though, that have shown that reservists report that they have dental insurance either through their employment or their spouse's employment. So there is—upwards of 60 to 70 percent say they have some type of dental insurance.

The demographics of young people, a lot of them, you know, their teeth are not the most important thing right then. And so, you know, the value they place on having—paying $11 to have the dental insurance is probably not, you know, to the level where they say, okay, yes, I will sign up for that program. So those are some of the factors that work into why, you know, that percentage is low, in the 8 to 10 percent.

We are doing everything we can to improve it. In fact, we incentivized our current contractor with an award fee if they can improve that percentage. And they have done quite a bit of marketing to that group to increase the rates.

To the second question, as to why do certain groups not utilize, nationwide, those who have dental insurance, it is about—a little over 50 percent actually will utilize a dental service. For the TDP it is much higher, at 71 percent.

Part of that, I think, is self-selection. People who are enrolling in the program know they have a dental need, and so they pay that money, and then they are going to go use it. And so that is why

I think you have a little bit higher utilization rate for that group of people.

Dr. SNYDER. Colonel Bodenheim, was it you that talked about this review that is going on with General Schoomaker?

Colonel BODENHEIM. Yes, sir.

Dr. SNYDER. You discussed that?

Now, that started—like, last month, sometime in March?

Colonel BODENHEIM. That is correct, sir.

Dr. SNYDER. What is going to be the product that comes out of that? Is there going to be a written report that will be available to all of us, or what is going to be the end result of that?

Colonel BODENHEIM. Yes, sir.

The prioritized list of initiatives is working through the Army leadership at this time.

Dr. SNYDER. And so you anticipate there will be a report that will be shared publicly and with the Congress and——

Colonel BODENHEIM. That is correct, sir.

Dr. SNYDER. And do you anticipate that will be sometime toward the end of May?

Colonel BODENHEIM. I was told that it should be within 90 days.

Dr. SNYDER. From—within 90 days from when it started, which was in March. So my math is pretty good.

There may be some things in there that we can be helpful with during the Defense bill markup. But that is going to be around the same time.

Do any of you have a report—I think some of you did, but specific legislative changes? One of you mentioned—I guess you, Captain Krause—about the need for additional full-time personnel. But are there specific legislative changes that we need to make or consider making?

We will just go down the line, starting with you, Colonel Martin.

Colonel MARTIN. The only one that I would—and this is in my opinion; the only one I would be interested in would be a little clarification in the TAMP dental benefit language that is currently out there, so that we could provide the appropriate—a more clear benefit for those who are being deactivated.

Dr. SNYDER. Colonel Bodenheim.

Colonel BODENHEIM. I would not want to comment on any legislative changes until the Army leadership has worked through the initiatives.

Dr. SNYDER. Colonel Sproat.

Colonel SPROAT. Sir, we had the two: the increase in age from 64 to 68 for our dentists, and then full-time manning for the Army National Guard.

Dr. SNYDER. Right.

Captain Krause.

Captain KRAUSE. I stand by what he said.

Dr. SNYDER. Colonel Hart.

Colonel HART. I have nothing to offer.

Dr. SNYDER. The two days medical readiness that I think you mentioned, that does not require a legislative change?

Colonel SPROAT. No, sir. That is Army policy.

Dr. SNYDER. Mr. Akin for five minutes.

Mr. AKIN. I don't have any further questions.

Dr. SNYDER. Mr. Buyer for five minutes.

Mr. BUYER. Thank you.

You know, Colonel Bodenheim, in answer to my first question about, did you know that these numbers were not fair and accurate, you thought for a moment and your answer was, "It was a method." You are right. In any form of enterprise, especially when foolishness occurs, there are different types of methods that are used.

Now, it is whether the method is credible or not is the question. Right? So the credibility of the Army Dental Corps with regard to how you handle this initiative is a question.

Now, others have had the opportunity to scrutinize your work product. They find it highly unusual and an aberration of customary practice. Now, that was either ordered to be done, somebody used some type of curious math for a purpose, and it was to deceive, I believe.

Now, you guys didn't know that Congress was involved in this, so obviously it was going to the surgeon general. At the time this was a surgeon general who then gets dismissed, and you guys must be tickled to death. Gee, this is going to go away, because it is not our mission. Even though now today you are telling me it is your mission.

You see, you guys are not out of the woods. I want you to know that. Because when you go on back down to San Antonio and they tell you, hey, how did it go up in Washington, you are not out of the woods. You are not out of the woods because, I suppose, I am upset.

Anybody that cares about their soldiers, making sure they get the proper care, should be upset, especially if we are going to make it part of the Army Force Generation (ARFORGEN) model.

Now, these initiatives that you don't want to talk about, I am not foolish, I can almost see this, we have got the leadership of the Army Dental Corps going, I don't like this study, we don't want to do demob, it is not our mission, we will cook the books, we will show the decision-making authorities it is not cost-effective.

You get caught. Then those who catch you go, oh, my, we had better do an assessment.

I asked your dental chief, what is this capabilities gap? See, I came to San Antonio with pure intent to fund capabilities gap and work cooperatively with the gentleman behind me, because I work with him also on the VA. That is not how I was treated.

Now I learn in your testimony that you have done your, quote, "capabilities assessment." Has that been complete, yes or no?

Colonel BODENHEIM. That capabilities assessment is still working through the Army leadership, sir.

Mr. BUYER. Okay. Working through the Army leadership. So it has been completed, but not signed off; that is what that means. So there is a number already attributed to this, but you are not willing to give it to the Armed Services Committee because somebody hasn't signed off. Okay.

You see, General Cody was going to come over here and tell me, but I asked him not to do that, because I wanted him not to testify to me in my position as the VA. I am working cooperatively with the Armed Services Committee. That is extremely important. That

is why I said, you guys are not out of the woods. You are in more trouble than you could ever imagine.

The credibility of the Army Dental Corps, it just bothers me so much. I have so many dentists in my family. I grew up as a kid, watching; my dad and I ready to go on a float trip and go fishing, and we can't because somebody has showed up who got his teeth knocked out in a Little League game. And the kid wasn't my dad's patient, but he takes care of him.

It is like you are going to take care of your active duty soldiers. But those guardsmen and reservists, they are not your patients; we will take care of them on premobilization (premob), but on demob, we are going to have somebody else take of care of them. We will have contractors take care of them, we will have the VA take care of them.

No, they are Army green. If we are going to buy into the ARFORGEN model, it all gets caught in the cycle; we here in Congress are prepared to do that.

So here is my message when you go back to San Antonio. You tell the general down there, stop fighting us and be forthright. No games. Tell him that for me?

Colonel BODENHEIM. Yes, sir.

Mr. BUYER. No games.

Now, I don't know where this is going to go. We will let the investigations continue. I can tell you how disappointed I was when Art Wu went back down a second time, and individuals whom he then spoke to had feigned memory.

Oh, I have been a prosecutor and I have been a defense lawyer, so I understand what feigned memory is. I don't recall, I don't have recollection, that may not be how it happened, that's not what I understood what was said.

Just be careful, okay?

Colonel BODENHEIM. Yes, sir.

Dr. SNYDER. I wanted to ask, the issue on the readiness of our Reserve component; I think it is an important issue. I think it came up twice with the 39th, and we have talked about that. You all think it is an important issue.

Are we making too big a deal about it? The bottom line is, it gets done. They get mobilized. Teeth get fixed adequately. Have you all done a cost analysis about whether the investment would get us where we would ideally like to be at the time of, you know, alert and mobilization? Is that going to be so cost prohibitive we are better off by sticking with our kind of scrambling-around method as we look for processes for the units to meet this goal?

I am playing a bit of devil's advocate. Does anybody have any comment there?

Colonel BODENHEIM. Sir, I will speak to that.

What we need to get out of is the idea of what I call "just-in-time dentistry." That is not the right thing for soldiers. So when you take a soldier to a mobilization platform and they are still in DFC 3 condition, not only are they losing training hours, but they are getting a lot of dentistry done in a short amount of time; and that is not the right way to treat soldiers.

What we need is a continuous, flowing system that allows Reserve component soldiers access to no-cost dental care on a year-

round basis, because we never know when an unalerted soldier is going to be cross-leveled as a replacement to a unit and then becomes an obstacle to the training of that unit.

For instance, on the 39th replacements that came after the main body had successfully validated, many of those soldiers had less than 30 days of training, or about a 30-day training period before they went off with their main unit. If those soldiers are not fixed or do not have the ability to be fixed at no cost prior to that time, then we are being unfair to that soldier to miss those training hours.

Dr. SNYDER. The issue of recruiting and retention of dentists, how are we going to solve that?

Colonel SPROAT. Sir, we have a program that is predecisional, but I can share with you that the Army National Guard takes the crisis very seriously. We plan to use state active duty dollars to put——

Dr. SNYDER. If I may interrupt, we consider the recruitment and retention of dentists a crisis?

Colonel SPROAT. Sir, we are getting there. When we have 60 percent of our dental billets filled, and 40 percent of those people are retirement eligible, when they are faced with a deployment, they may drop their papers. The numbers decrease every day.

Dr. SNYDER. I interrupted you. Please continue.

Colonel SPROAT. Yes, sir.

We have a new program for medical and dental students where we put them on active duty at their medical or dental school as a recruiter. This is a Guard program, and basically they recruit their fellow students.

We pay them as second lieutenants. They receive a housing allowance. They do not receive any tuition assistance, but this enables them to have a good standard of living while they are in dental school or medical school. And then they can also take advantage of additional Guard programs when they are in their residency programs or their training programs to pay back their tuition.

So we think this is an innovative program that is in the last stages of approval. And we think that is going to be a very good fix five to six years from now when we have those graduates coming into the Guard.

Dr. SNYDER. Do any of you have any comments about the issue—I think it was mentioned by more than one of you—on the issue of medical records and electronic medical records? Is that exacerbated in the area of dentistry, the issue of transferability of medical records? Does anybody have any comments?

Colonel BODENHEIM. Sir, I will comment.

As far as electronic dental records, you saw my written testimony that DENCLASS, originally created for the Army National Guard as an electronic exam system record and tracking system, will be expanded to the U.S. Army Reserve; as well, the Reserve Health Readiness Program will use it.

One of the number one reasons for soldiers presenting as a no-go at a mobilization site is due to missing records or parts of missing records. And so we will be able to solve many of those issues of reexamining a person because we don't have a record showing their DFC rating and the ability to validate that record.

Dr. SNYDER. You have anything further?

Mr. AKIN. Just to piggyback on your statement, you said the best way to handle dental care is on a consistent basis. You don't just do this emergency and then let it run for 10 years and find you got a mouthful of trouble when you come back.

Is the implication of that, then, that you would have people who were on Reserve covered? Are you saying they would be covered under some type of dental care then?

Colonel BODENHEIM. Well, currently a soldier is permitted to have an annual exam regardless of their alert status. Upon alert, they are allowed to get DFC, or Dental Fitness Class, 3 treatment done at that time.

What I am stating is that we need to expand this to unalerted soldiers so that we do not have the problem with cross-leveled soldiers or replacements, causing lost training time at mobilization sites, and to get us out of the just-in-time dentistry mode, which is not how any of us would want to be treated in our own treatment.

Mr. AKIN. So you are saying somebody who has not been activated, but is in Reserve.

Currently, my understanding is, they can be covered one of two ways: Either they have this insurance that goes up to $1,200, or they are just paying for it out of their pocket, or maybe their employer gives them something or whatever it is.

Colonel BODENHEIM. That is correct.

Mr. AKIN. And you are saying, you would like to see those people making sure they all have got solid dental care, so that they don't carry the dental problem in as soon as you activate them.

I think that's what you are saying, right?

Colonel BODENHEIM. That is correct, sir. And no cost to the soldier.

Mr. AKIN. At no cost.

So who is going to pay for it then, would you say? Who would pay for that program then? Or is that something that is in your plan?

Colonel BODENHEIM. Those would be part of the initiatives working through the Army leadership.

Mr. AKIN. Okay. And so—but can you say who would pay for that? Is that going to be a Department of Defense expense or would that come from somewhere else?

Colonel BODENHEIM. I would like to take that question for the record.

Mr. AKIN. Okay. That's fine as far as I am concerned. Thank you.

That's all I have, Mr. Chairman.

[The information referred to was not available at the time of printing.]

Dr. SNYDER. Mr. Buyer has a final question.

Mr. BUYER. Thank you. Really there are two.

There is a demob reset question. And when you go back and said, okay, it is our mission, the numbers were recalculated, it shows that this—that the dental exam study, once they recalculated the numbers, showed that it was cost-effective, i.e., then success.

Can you tell me whether there was any planning done to do future-type actions against brigades, to do future demob for brigade-size assets that are returning based on the success of this study?

Colonel BODENHEIM. We have plans that are available to do reset based upon this study.

Mr. BUYER. Okay. All right. Wait a minute. Then based on the study. Wow. Okay.

So now, wow, that testimony that you did down in San Antonio, that was all a mistake? Now that they have been recalculated, you have now bought into, yes, it is cost-effective, it is our mission; and planning for that success is occurring right now is your testimony?

Colonel BODENHEIM. Sir, what I meant to say is that we know the number of personnel that it would take, the facilities, et cetera, in order to do the mission.

Mr. BUYER. All right.

The demob reset, is it 1 year plus 90 days is the demob reset? Do you know what the demob reset is?

Colonel BODENHEIM. I am unsure of the question.

Mr. BUYER. Can you turn and ask somebody who may know?

Colonel BODENHEIM. At present it is 180 days.

Mr. BUYER. Are you kidding me? When did this occur?

Colonel BODENHEIM. This occurred recently.

Mr. BUYER. How recent? You were 1 year plus 90 days. Now you have gone to 180 days. Was that an evidence-based decision or did somebody capriciously push it off another 90 days?

Colonel BODENHEIM. I do not know that answer, sir.

Mr. BUYER. Who made the policy decision to push it another 90 days?

Colonel BODENHEIM. I cannot answer that question.

Mr. BUYER. You cannot answer it because you know and won't tell me, or you do not know what the answer is?

Colonel BODENHEIM. I do not know what the answer is, sir.

Mr. BUYER. See, Mr. Chairman, this is really pretty concerning, because if the Army is basically—first of all, it is concerning when they do an annual plus 90 days because they are then saying that the 90 days is an acceptable level of neglect.

Now—the acceptable level of neglect is now another 90 days, which is 180 days before you can ever do a reclassification. That means the Army active duty dental corps is not going to be doing dentistry for our guardsmen and reservists.

What is the justification—give me your personal opinion; that is what you like to give—give me your personal opinion on why 180 days is a good policy or not.

Colonel BODENHEIM. My personal opinion, sir, is I was surprised by the 180 days.

I cannot answer where it came from because I do not know.

Mr. BUYER. Okay. If you are surprised, would you advocate to change it, to change that policy?

Colonel BODENHEIM. I would advocate to change it.

Mr. BUYER. You bet. All right.

I yield back, Mr. Chairman. That needs to be changed.

Dr. SNYDER. Gentlemen, thank you all for being here. We kept you about 2-1/2 hours. I apologize for the votes.

Members may have some questions for the record.

Dr. SNYDER. We certainly would like to hear the results as your decision-making process completes itself with General Schoomaker and others; and I hope you will share that with the committee.

We are adjourned.

[Whereupon, at 5:03 p.m., the subcommittee was adjourned.]

A P P E N D I X

APRIL 23, 2008

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

APRIL 23, 2008

Opening Statement of Chairman Dr. Vic Snyder
Subcommittee on Oversight and Investigations

Hearing on "Challenges Associated with Achieving Full Dental Readiness in the Reserve Component"

The hearing will come to order.

Good afternoon, and welcome to the Subcommittee on Oversight and Investigations' hearing to discuss the challenges associated with achieving full dental readiness in the Guard and Reserve.

The reserve component is transforming from a strategic to an operational reserve. We need to give our men and women in the Guard and Reserve the tools they need to take up this mission. The most important thing that they bring to the table is their health, the medical and dental readiness of the force. Oral health is an often overlooked, but extremely important aspect of overall pre-deployment readiness.

DOD has said that 95% of military personnel, active and reserve, should fall into the Class 1 or 2 dental fitness categories, meaning that they are healthy enough to deploy. Right now, none of the Services are meeting these goals for the reserve component. But the Army and Marine Corps have struggled the most. This is a public health issue, and also a readiness issue. Only 43.2% of the Army National Guard, and 50.6% of the Army Reserve is currently ready to deploy. Only 77.7% of the Marine Corps Reserve is ready to deploy. But since none of the Services are meeting the DOD goal, I hope we're going to figure out why.

Today we will hear about some of the challenges the services face, and I hope we will hear some good ideas about how these issues can be addressed. I know that the Army National Guard's 39th Infantry Brigade, in my home district in Arkansas, struggled with many of these challenges when they recently deployed to Iraq for their second tour. I am proud of their hard work and the creative ways in which they accomplished the pre-mobilization readiness mission under adverse conditions. But they encountered additional challenges at the mobilization station.

We should not be waiting until mobilization, or even until alert, to prepare our fighting men and women. Dental care and oral health must become a regular part of the routine, as it already is with our active duty forces. Increasing our emphasis on oral health overall will reduce pressure on units in the months before deployment. They should be focusing on preparing to meet their mission in theater, not scrambling to get their dental work done so that they can train and deploy.

Improving dental readiness rates in the reserve component will require a combination of command emphasis, accountability on the part of individual service

members, and possibly programmatic changes. That's what we're here to talk about today, and I am looking forward to a good discussion.

We are joined today by a group of witnesses who are responsible for caring for the oral health of our reserve component:

Colonel Gary Martin, USAF
Chief, Dental Care Branch
TRICARE Management Activity

Colonel Mark Bodenheim, USA
Chief, Reserve Component Mobilization and Demobilization Operations
U.S. Army Dental Command

Colonel David Sproat, USA
Chief Surgeon
Army National Guard

Captain Kerry Krause, USN
Reserve Affairs Officer
U.S. Navy Dental Corps

Colonel Deborah L. Hart, USAF
Mobilization Assistant to the Air Force Assistant Surgeon General for Dental Services
Office of the Surgeon General, U.S. Air Force

Thank you all for being here. I know that you are working hard on this issue. After Mr. Akin's opening remarks, I'll turn to each of you for a brief opening statement. Your prepared statements will be made part of the record.

April 23, 2008

Opening Statement of Congressman Todd Akin

Subcommittee Hearing on Achieving Operational Dental Readiness in the Reserve Components

"Today's hearing clearly demonstrates the value of our subcommittee and the good we can do for our men and women in uniform. At first glance, dental readiness may not seem to be a subject the Congress would focus on, and in fact, I'm not aware of previous hearings on this topic. Upon greater reflection though, all would conclude that dental readiness is a very timely and critical topic. Armies throughout history have suffered more casualties from sickness than from combat inflicted wounds, and today's military forces are no exception. Indeed, medical and dental readiness are key components of insuring units are ready to deploy and effectively perform their missions in combat.

"Our witnesses are well grounded in the challenges of insuring members of the Army, Navy, Marine Corps, and Air Force reserve components are dentally ready to deploy and in the effectiveness of Department of Defense and individual service approaches to this issue. I would not want to be in their shoes. I cannot imagine a more difficult job than theirs: find ways to entice relatively junior reserve component servicemembers, most on limited income, to undergo periodic dental examination and treatment with sometimes minimal reimbursement, so that they can deploy to Iraq for 12 to 15 months. Frankly, I'm surprised anyone goes to the dentist with a combat tour in Iraq as the reward for compliance.

"In reviewing your testimony, I understand that each component faces somewhat different obstacles and has chosen to manage the problem in different ways. I look forward to hearing about your programs and any recommendations you may have of how we in Congress can help to make your job easier and provide our reserve component men and women better dental health."

PREPARED STATEMENT

BY

COLONEL GARY C. MARTIN, USAF, DC
CHIEF,
DENTAL CARE BRANCH
TRICARE MANAGEMENT ACTIVITY
OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
FOR HEALTH AFFAIRS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 23, 2008

NOT FOR PUBLICATION UNTIL
RELEASED BY
COMMITTEE ON ARMED SERVICES

Mr. Chairman and distinguished members of the committee, I thank you for your strong interest in improving the dental readiness of Reserve and National Guard Service members. As the Chief of the Dental Care Branch at the TRICARE Management Activity, I am responsible for the management of the various Department of Defense (DoD) dental programs that provide care to over 9.2 million eligible beneficiaries. Today, I will provide a brief explanation of DoD's dental readiness classification system; discuss the current state of Reserve Component (RC) dental readiness; and give an overview of dental programs available to Reserve Component members. The Services will address the challenges they face to improve RC dental readiness and describe their initiatives to address the challenges.

As stated in Health Affairs (HA) Policies 06-001 and 07-011, the DoD dental readiness goal is to have 95 percent of all U.S. forces worldwide deployable. For over 24 years, DoD has successfully gauged the dental readiness of the Services, both Active and Reserve Components, through use of an Oral Health and Readiness Classification System. The Department revised the current classification system, as described in HA Policy 02-011, in June 2002. The various dental readiness classifications are:

- Dental Class 1 – Individuals with a current dental examination, who do not require dental treatment or re-evaluation. Healthy service members who are worldwide deployable;
- Dental Class 2 - Individuals with a current dental examination, who have oral conditions/diseases that require non-urgent care or re-evaluation. These are oral conditions, which are unlikely to result in a dental emergency within 12 months. Service members who are worldwide deployable;
- Dental Class 3 – Patients who require urgent or emergent dental treatment that if not accomplished will likely result in a dental emergency within 12 months. Class 3 individuals are considered **not worldwide deployable**; and
- Dental Class 4 – Individuals who have not accomplished their periodic dental examinations or patients with unknown dental classifications and are considered **not worldwide deployable.**

Current Dental Readiness Status

When comparing the Department's quarterly reports on the Individual Medical Readiness (IMR) for Active Components for the first quarter of fiscal year (FY) 2008 with the first quarter of FY 2007, each of the Services has shown progress in meeting the DoD goal of 95 percent dental readiness. The Air Force

is the only Service, however, that meets or exceeds the goal with 98.3 percent of their personnel being dentally ready. Currently the Army is at 87.3 percent, the Navy 87.0 percent and the Marines are 76.8 percent.

When comparing quarterly IMR reports for Reserve Components for the first quarter of FY 2008 with the first quarter of FY 2007, there has not been any significant change. None of the Services meets the DoD goal of 95 percent dental readiness. As of 1 December 2008, the Army National Guard was at 43.2 percent, Army Reserve 50.6 percent, Marine Corps Reserve 77.7 percent, Air Force Reserve 84.9 percent, Air Force National Guard 88.8 percent, and the Navy Reserve was 90.0 percent.

It is important to understand some basics about dental readiness. The majority of the Class 3 dental conditions in our service members are a result of dental decay (caries), and dental decay is a chronic infectious disease. To properly treat and prevent dental decay, individuals at high risk for this disease must modify their diets and eating behaviors and practice effective daily oral hygiene. If these measures are not taken, dental decay may recur in the same teeth that previously received treatment. Frequently, the recurrence of disease will result in a more extensive treatment need which may include a larger filling, a root canal and/or a crown.

Several studies have validated the importance of DoD's Oral Health and Readiness Classification System. A study by the Tri-Service Center for Oral Health Studies, published in *Military Medicine* in October 2007 showed the dental emergency rate for Class 3 personnel is 8.8 times higher than personnel in Class 1 and 3.9 times higher than the rate in Class 2 personnel. A recent report on 900 Air Force personnel deployed for 120 days found that only 1.7 percent received any needed dental care during the deployment. This demonstrates that if we deploy personnel in good oral health, their chances for a dental emergency during the deployment are significantly reduced.

Dental Programs for Reserve Component Members

TRICARE Dental Program

In various surveys, to include the Status of Forces Survey of Reserve Component members, approximately 70 percent of reservists have responded that they have some form of dental insurance provided by their civilian employer. For those Reserve Component members without employer-sponsored dental insurance, DoD offers the TRICARE Dental Program (TDP), a comprehensive

dental insurance program for Active Duty family members, Reserve Component members and their families.

Over the past two years, there have been about 8 – 10 percent of eligible Reserve members who have elected to enroll in the TDP. The Air Guard has the highest enrollment with 21.8 percent. The lowest enrollment rate is the Marine Corps Reserve with only 2.8 percent enrolled. The Government pays 60 percent of the monthly premium with the reservist paying 40 percent; currently a reservist pays a low monthly premium of $11.58. There is an annual maximum payment for dental services of $1,200 with cost shares for the more expensive procedures such as root canals, crowns, extractions. Most preventive services are covered at 100 percent and do not count toward the annual maximum. There is also coverage for orthodontics with a lifetime maximum payment of $1,500.

For FY 2007, 71.6 percent of the reservists enrolled in the TDP utilized at least one covered procedure. The TDP network of dentists is quite large with over 84,434 participating dental offices. This includes 63,555 general dentist locations and 20,769 specialist locations. The current reimbursement rates for participating dentists are adequate as evidenced by the high number of participating dentists in the program. However, there are some areas in the U.S. where the reimbursement rates have been adjusted upward to improve access to care.

Reserve Health Readiness Program

In addition, the Reserve Health Readiness Program (RHRP) provides medical and dental care for reservists. The RHRP has a network of contracted dentists that provides dental exams and Class 3 treatment needs to assist reservists in achieving and maintaining dental readiness. During the past 12 months approximately 180,000 reservists received their annual dental exams and 7,500 Class 3 patients received required dental care. The vast majority (92 percent) of these reservists who received their exams and required treatment were Army.

Early Activation Dental Care

Reservists on 90-day early activation orders are eligible for dental care at the same level as Active Duty Service members. The majority of this dental care is provided in military Dental Treatment Facilities (DTFs); however, when needed, referrals are made to dentists in the private sector. Private sector dental care for Active Duty personnel is managed by the TRICARE Management Activity. Currently this program is administered by personnel at the Military Medical Support Office in Great Lakes, Illinois.

Transitional Assistance Management Program

The Transitional Assistance Management Program (TAMP) includes a dental benefit for recently de-activated or separated military members. This dental benefit provides space available care in military DTFs for 180 days from the date of leaving Active Duty status. It should be noted that very few DTFs have space available to treat these members. But, Reservists who are deactivated and who will remain in the Reserves are eligible to enroll in the TDP.

Department of Veterans Affairs (VA)

Finally, all Service members who are separated from Active Duty receive a DD Form 214, Certificate of Release or Discharge from Active Duty. A section of this form documents whether there are any dental conditions requiring treatment that DoD could not provide prior to separation. If treatment is required, the member may apply for treatment to the VA within 180 days of release from Active Duty. The VA will notify the member of their eligibility status for this treatment. On average, about 18 percent of eligible deactivated Reservists have utilized this benefit over the past three years.

Conclusion

Mr. Chairman, distinguished members, thank you for your interest in improving the dental readiness of our National Guard and Reservists. As you can see, the Department offers several options to improve the dental readiness of these Service members. We look forward to your continued support as we implement new and improved programs to improve the oral health of Reserve Component members.

FINAL VERSION

STATEMENT BY

COLONEL MARK BODENHEIM
UNITED STATES ARMY DENTAL COMMAND

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

23 APRIL 2008

I am Colonel Mark Bodenheim and I want to thank the Committee Members for allowing me to speak to you concerning the present state and future initiatives concerning Army Reserve Component dental readiness. I am a U.S. Army Reserve Dental Officer of 35 years and I have been voluntarily mobilized for more than five years to serve as the Chief of Reserve Component Mobilization Operations for the U.S. Army Dental Command. In my civilian employment, I am the Dental Director for a 13 county, clinical dental public health program in North East Georgia.

Army Active Component Dental Readiness - Historical Perspective

A short historical perspective is appropriate in order to understand the challenges in achieving full dental readiness in the Army Reserve Components (RC). In response to dental non- battle injury emergency rates averaging sixteen percent during Vietnam, in 1968 the Army implemented the Oral Health Maintenance Program to target Army Active Component (AC) Soldiers through an annual dental exam and treatment program. During the 1980s, the Army Dental Care System initiated the Oral Health Fitness Program which identified potential high risk dental casualty Army AC Soldiers through the use of a Dental Fitness Classification (DFC) system, DFC 1 thru DFC 4, which continues in use today. Army AC commanders began receiving monthly reports on the dental readiness of their AC Soldiers and only those with a GO (DFC 1 or DFC 2) rating were recommended for worldwide deployment. During this period, the Health Services Command dental directorate (now U.S. Army Dental Command or DENCOM), set goals to maintain the Army AC at a 95% DFC 1 or DFC 2 dental deployment status. Subsequent studies continued to show that DFC 3 deployed Soldiers experienced

significantly higher dental emergency rates than DFC 1 or DFC 2 Soldiers. A DFC 3 Soldier is 8 times more likely to have a dental emergency than a DFC 1 Soldier and 4 times more likely than a DFC 2 Soldier. For the Army AC, dental readiness coordinators located at DENCOM dental treatment facilities (DTFs) review monthly unit dental readiness status reports, creating lists of AC Soldiers who are due for their annual exam, and if found to be DFC 3, prioritize subsequent treatment. The unit command structure has high visibility of unit dental readiness status reports and has command directive capability to order AC Soldiers to attain deployment DFC status.

Army Reserve Components Dental Readiness - Historical Perspective

In contrast, the Army RC, which now consists of over 550,000 Army National Guard (ARNG) and U.S. Army Reserve (USAR) Soldiers, did not share the same command-directed dental readiness history. The lack of a dental readiness program was evident during the First Gulf War as reported in a March 2001 American Forces Information Services News Article which quoted an Army Reserve source stating "roughly 35-45 percent of Army Reservists activated during the Gulf War needed dental work before they could deploy." A February 2004 testimony to the House Armed Services Committee, Total Force Subcommittee, by The Military Coalition, a consortium of nationally prominent uniformed services and veterans' organizations stated, "the number one deployment problem in the First Gulf War was dental 'un-readiness' and the same is true today." In 1998, the Department of Defense issued a policy directing that Active Duty (i.e. Active Component) and Selected Reserve personnel (excluding members of the Individual Ready Reserve or IRR) complete a periodic dental examination on an annual basis. In 2000, the TRICARE Dental Program (TDP)

provided the first Army RC dental readiness system. This was an optional program requiring the Soldier to pay monthly premiums and treatment co-payments. The financial burden on Soldiers is considered a contributing factor to the poor enrollment rates that continue today (7.0% ARNG, 5.1% USAR). Army RC units mobilized between 1997 and 2001 presented to mobilization platforms with DFC 3 rates between 14-36%. In 2002, the contracted Federal Strategic Health Alliance (FEDS_HEAL) dental network provided pre-mobilization dental "screenings" at no cost to Army RC Soldiers in an attempt to improve dental readiness. NO GO (DFC 3 or 4) rates showed little improvement with Army RC Soldiers presenting to mobilization platforms from January-August 2002 with DFC 3 rates of 25%. By November 2002, a series of incremental statutory and policy changes were implemented which authorized examinations and DFC 3 treatment at no cost to the Soldier upon receipt of mobilization orders. Because mobilization orders were frequently issued less than 60 days ahead of the mobilization station arrival date (MOBSAD), the Army realized little improvement in dental readiness. Army RC Soldiers were then authorized to receive DFC3 treatment upon an alert order in an attempt to improve available time for dental readiness examination and care prior to MOBSAD. Again, improvements in MOBSAD dental readiness GO rates were not realized because the alert orders and the mobilization orders were being issued almost simultaneously shortly before MOBSAD. These fractured and incremental approaches to Army RC dental readiness, and the prolonged training periods at the mobilization platforms prior to deployment, were the major reasons for a "fix it at the mobilization station" attitude by Army RC unit commanders. Over 87% of Army RC Soldiers were reporting as a "NO GO", with a DFC 3 rate of 19%, according to mobilization platform report rate statistics in February 2004.

Standardizing Army RC Dental Readiness and Army AC Mobilization Processing

In June 2003, the DENCOM commander directed the evaluation of Army RC pre-mobilization dental readiness exam standards. At that time, Army Regulations permitted Army RC Soldiers to receive cursory dental screenings without the use of a mirror, probe, or supporting radiographs to establish a DFC. In addition, exams were being documented inconsistently by the pre-mobilization contracted providers. This led to massive re-examinations at the mobilization platform in order to meet Army AC exam standards. Working with the dental surgeons of the National Guard Bureau (NGB) and the U. S. Army Reserve Command (USARC), the "One Army" dental exam standard for the Army RC was initiated in April 2004. It was published in Army Regulation 40-501 in February 2005. By September 2005, the "GO" validation rate of Army RC Soldiers presenting to mobilization stations improved to 51% mainly due to the exam standard implementation. DFC 3 rates remained at a high level of 22%, mainly due to the new Army RC exam standard identifying more DFC 3 Soldiers. The DENCOM Commander further directed standardization of dental Soldier Readiness Processing (SRP) at the mobilization platforms to ensure consistent validation processing throughout DENCOM SRP dental stations. A comprehensive, operational processing standard was issued by DENCOM in July 2005 which improved processing efficiency, permitted detailed data reporting, and reduced the duplication of pre-mobilization dental readiness processes. A DVD training video, power point presentation updates to the DVD, and an extensive, detailed mobilization dental requirements section located on the DENCOM web page are used for training Army RC unit commanders, DENCOM, ARNG and USAR dental personnel on these changes. Additionally, over the past two years, the Office of the

Surgeon General dental consultant has chaired the Dental All Army Working Group which consists of dental representatives from the NGB, USARC, the Reserve Health Readiness Program (RHRP which replaced FEDS_HEAL), and DENCOM to continue standardization improvements of the Army RC dental readiness system. The major achievement of this group was the improvement of the existing ARNG electronic dental exam record/tracking system, DENCLASS; its implementation for the USAR and RHRP by May 2008; and the creation of the Army Dental Digital Repository (ADDR), hosted by the Army AC, which integrates dental data collected from Army AC dental treatment facilities, Army RC dental readiness programs using DENCLASS, and Army AC mobilization platforms.

Present State of Army RC Dental Readiness

Army RC dental readiness can interfere with deployed theater operations and with mobilization platform pre-deployment training. An internal DENCOM study estimated that an average of 11 hours of duty is lost for each DFC 3 RC Soldier performing pre-deployment training at the mobilization platform due to appointment time, transit time, oral surgery healing time and escorts for Soldiers sedated for oral surgery. In Fiscal Year (FY) 2006, an estimated 9500 ten-hour training days were lost at mobilization platforms due to DFC 3 treatment and in FY07 an estimated 6600 ten-hour training days were lost. Thus far in FY08 through the end of the 2nd quarter, we estimate over 3500 training duty days have been lost. Another internal DENCOM study at Camp Shelby from Feb-May 2007, determined that over 23% of the DFC 3 Soldiers required more than 30 days to attain a minimum DFC 2 deployment status due to the difficulty of appointing intensive care DFC 3 Soldiers without conflicting with their

training time and the recovery periods required after oral surgery. Clearly, DFC 3 treatment and the state of Army RC dental readiness must move to the left of the MOBSAD.

Table 1 shows the dental readiness state of Army RC Soldiers presenting to mobilization platforms over the past two and one-half years.

TABLE 1	Army RC Mobilization Station Dental Readiness Validation Rate					
Date Range	FY06		FY07		FY08 (Q1+Q2)	
Component	ARNG	USAR	ARNG	USAR	ARNG	USAR
GO	56%	36%	61%	40%	80%	52%
NO GO	44%	64%	39%	60%	20%	48%
DFC 3	17%	23%	15%	17%	9%	14%
Source:	DENCOM Corporate Dental Application (CDA) RC Mobilization Module					
Legend:	DFC 1 + DFC 2 = GO DFC 3 + DFC 4 = NO GO					

I use FY06 as the initial baseline for comparison because by October 2005, the Army RC and their contracted dental readiness entities, as well as DENCOM mobilization platform dental stations, had standardized exam documentation and mobilization validation processing requirements. We saw steady but slow improvement through FY07. During the first half of FY08, more dramatic improvements occurred, especially by the ARNG Brigade Combat Teams (BCTs). I attribute these improvements in dental readiness to a combination of 1st Army command emphasis directed at the BCT commanders, dental readiness systems initiated earlier in the alert phase compared to previous history, and diligent work done by the state dental surgeons. The 39th BCT from Arkansas exemplified this improvement. The 39th began its exam process in the summer of 2007 for a January 2008 MOBSAD at Camp Shelby. The unit used both RHRP and a direct contractor (Onsite Dental). The 39th conducted multiple SRPs through the months leading up to the MOBSAD. In addition, Camp Shelby dental

personnel instructed ARNG personnel on the ground in Arkansas on dental readiness standards.

In Table 2, the recent ARNG BCT mobilization platform validation rates are compared to the smaller unit validation rates at different mobilization platforms and demonstrate that the dental readiness of smaller units is less predictable. Small units may have less command influence and they are more directly affected by cross-leveled Soldiers from non-alerted units. Cross-leveling occurs in both Reserve Components, but is more prevalent in USAR units. It occurs prior to the unit MOBSAD and continues after the MOBSAD. As an example, the 39th BCT had nearly 190 Soldiers (6% of total BCT) cross-leveled into the unit after the MOBSAD with 54% presenting in a NO GO status and after examination 26% were classified as DFC 3. One Soldier was Released From Active Duty (REFRAD) for dental issues. By contrast, the main body of the 39th BCT had no REFRADs. These statistics highlight the crux of Army RC dental readiness – in order to operationalize the Army RC, all Army RC Soldiers, even those from non-alerted units, must continually maintain a GO state of dental readiness.

TABLE 2	Army RC Mobilization Station Dental Readiness Validation Rate					
UIC/Unit Name	Compo	SRP Date	Mob Site	GO	NO GO	DFC 3
27th BCT	ARNG	Jan 08	Bragg	97%	3%	3%
39th BCT	ARNG	Jan 08	Shelby	88%	12%	8%
76th BCT	ARNG	Dec 07	Atterbury	87%	13%	8%
45th BCT	ARNG	Oct 07	Bliss	80%	20%	12%
37th BCT	ARNG	Jan 08	Hood	78%	22%	7%
WP8TAA - 1175 MP CO	ARNG	3-Mar-08	Dix	74%	26%	14%
WSTLAA - 894 QM CO	USAR	27-Feb-08	Dix	26%	74%	27%
WP1LT0 - 201 EN BN- HHC	ARNG	6-Mar-08	McCoy	67%	33%	19%
WRZUAA - 955TH EN BN	USAR	2-Apr-08	McCoy	61%	39%	29%
WTHFAA - 1710 TC	ARNG	13-Mar-08	Atterbury	69%	31%	14%
WS0VAA - 846th TC	USAR	2-Apr-08	Atterbury	46%	54%	33%
WP6ZAA - 2228 MP	ARNG	26-Mar-08	Shelby	94%	6%	3%
W8JCAA - 1186th TRAN	USAR	12-Mar-08	Shelby	63%	37%	14%
Source:	DENCOM Corporate Dental Application (CDA) RC Mobilization Module					
Legend:	DFC 1 + DFC 2 = GO DFC 3 + DFC 4 = NO GO					

Army RC Mobilization Processing

I would like to provide a synopsis of mobilization processing. Using the 39th BCT as an example, the unit provided dental records to the Camp Shelby SRP dental station prior to their MOBSAD validation processing. Pre-screening validation of each record occurs with an initial record audit by dental assistant personnel to confirm the presence of all required documents to include: a current (within 365 days) exam documented to the standard; supporting radiographs for diagnostic purposes; a panoramic radiograph that reflects the Soldier's current oral condition for diagnostic and forensic purposes; and a DFC of 1 or 2. If documents are missing, the audit personnel are required to look in the ADDR for those documents and print them for inclusion in the record. Then each record is reviewed by a dentist who validates the GO or NO GO status of the record to include quality assurance reviews of radiographs or written documentation. After the unit arrives at the mobilization station, Soldiers are processed through a "live" validation SRP process. This is set up the same way as the pre-SRP record screen process with

the addition of a data entry desk that populates the RC mobilization module in the DENCOM Corporate Dental Application (CDA). Those Soldiers with pre-screened GO records will go directly to the validation dentist who will ask the Soldier if they have any dental problems since their last exam (~3% do). If they do have a new dental problem, they receive an exam and are appointed for DFC 3 treatment if required. Validated GO Soldiers proceed to the CDA data entry desk for entry into the mobilization module which populates MEDPROS and the CDA unit tracking system. The process takes less than two minutes. A Soldier with a pre-screened NO GO record proceeds to the record audit desk to determine if any new dental documentation is presented by the Soldier. The record is then reviewed by the validation dentist. All NO GO Soldiers receive an examination and their DFC entered into CDA. DFC 3 Soldiers receive appointments within the facility and through a contracted network of providers at certain locations. Any DFC 3 Soldier with treatment requirements that cannot be completed before their deployment date is recommended for a dental REFRAD. In FY07, over 39,000 Army RC Soldiers processed through mobilization platforms and over 5,900 (15%) were determined to be DFC 3. Only 25 Army RC Soldiers were specifically REFRAD for dental reasons in FY07. All others were deployed as a DFC 1 or 2 - a testament to the Herculean efforts at mobilization platforms to deploy dentally fit RC Soldiers.

Army RC De-Mobilization Processing

Current demobilization processing is outlined in Annex B (Dental Processing) to the MEDCOM Demobilization Plan. Details of the plan can be found on the DENCOM web page under the demobilization processing requirements section which is accessible to the public. Demobilization occurs within a 4-6 day period and a Soldier's unit is made

available to the SRP dental station for a 1-2 hour period during the demobilization process. Soldiers present to the record audit desk of the SRP dental station where specific forms are reviewed. If available, the dental record is reviewed and the Soldier is given a one-page handout describing their three post mobilization options: Department of Veterans Affairs (DVA) dental benefit; Transitional Health Benefits; and enrollment in the TRICARE Dental Program (TDP). Each Soldier is given a DVA form 10-10-EZ and has 180 days to contact the DVA to coordinate dental treatment. Then each Soldier is given a dental treatment record form with the pre-stamped statement: "Member was provided a complete dental exam and all appropriate dental services and treatment within 90 days prior to separation." The "NO" block is checked, which permits the DD214, statement 17 (same as record statement) block to be checked "NO" and allows the demobilizing soldier to gain access to VA provided dental care. Army RC Soldiers who present with emergency conditions are scheduled for examination and treatment at the demobilization DTF.

Current Challenges to Army RC Dental Readiness

The most immediate way to improve the Army RC IMR-Dental statistics (see Table 1), would be to enforce current policy that directs all SELRES personnel to undergo an annual dental examination. The first and foremost way to improve dental readiness is command emphasis and support at all levels. The Army Reserve leadership must hold unit commanders and individual service members responsible for the member's readiness to deploy. The individual has personal responsibilities and the unit must provide monitoring and processes to ensure readiness.

However, the challenges are considerable. Consider these contrasts: the AC Soldier is assigned to a limited number of installations (except for a small percentage of detached duty Soldiers, i.e., recruiters, ROTC instructors) with supporting DTFs located where the Soldier either lives on post or in the nearby community. The AC Soldier does not lose pay for attending dental readiness appointments, as it is considered part of the job description. The AC Soldier receives dental care at no cost regardless of their alert status; and their dental readiness is managed by DTF dental readiness coordinators and unit command staff. By contrast, the RC Soldier is assigned to one of hundreds of ARNG armories or USAR centers and can live some distance from those sites, and must take time from work (many from hourly paid jobs without sick leave benefits) to attain dental readiness. The RC Soldier may receive an annual dental exam at no cost regardless of alert status, but can only receive DFC 3 treatment at no cost upon alert or mobilization status, thereby reducing the incentive to improve their dental health. The RC Soldier's dental readiness is managed by unit administrators overwhelmed with other administrative priorities, forcing them to relegate the importance of dental readiness to an impending unit mobilization.

Since 2004, DENCOM has operated the First Term Dental Readiness (FTDR) program, which was designed to evaluate and treat Army AC and RC Soldiers during initial entry training (IET) and subsequent Advanced Individual Training (AIT). Full training schedules and rigorous timelines to complete IET and AIT make it difficult for Soldiers to receive comprehensive dental treatment. The program is presently focused on examining and treating DFC 3 Soldiers who are identified through a Panoramic radiograph screening. Additional challenges include the fact that there is over a 40% surge of Army RC Soldiers in IET during the three summer months. At the same time

the Army AC direct care system experiences the summer underlap (PCS moves, REFRAD, etc). Contracted solutions are not readily available in the dental contracting community due to the summer surge's episodic, short term nature, and the difficulty of hiring at several IET sites. The challenges to expanding the FTDR program to include examination of all Army RC Soldiers at IET are: access to Soldiers to address all dental requirements during training (TRADOC limitation); facility constraints in the number of dental treatment rooms (DTRs) available; and adequate staffing (core mission staff, AC Dental officers and Civilians, perform 45% of present FTDR workload).

Resetting Army RC dental readiness during demobilization has the potential to improve baseline readiness of the entire population by approximately 10%, but is not without significant challenges. Since January 2004, mobilization SRP dental stations were authorized staffing based upon a 90% MOBSAD GO report rate and an administrative, not clinical, demobilization protocol. The statistics in table one indicate that the 90% GO rate has not been achieved on a consistent basis resulting in DENCOM core mission staff augmenting mobilization processing. Four of the mobilization platforms that process over 50% of Army RC Soldiers are located at ARNG and USAR installations that have minimal dental facilities and constraints to expand those facilities; these would need to be augmented substantially, or demobilization would need to take place elsewhere. An improvement in Army RC dental readiness GO rates at mobilization platforms would permit a limited redirection of mobilization platform staff to the demobilization mission. Expanding dental readiness access during Army RC annual training through expanded clinic hours or weekends also requires major enhancements in existing provider contracts.

Current and Future Initiatives

Within his first 100-days as Army Surgeon General, LTG Eric Schoomaker directed a complete review of RC dental readiness. The Assistant Surgeon General for Force Projection assembled a multi-component work group in March 2008 to conduct a capabilities-based assessment and develop a prioritized list of courses of action. These courses of action are currently being worked through the Army staff and will seek to address every aspect of RC dental readiness. These initiatives cover a full range of options that will enhance readiness. The solution sets require further refinements and senior leadership approval, but we are moving forward with urgency.

In order for the RC to become a truly operational force and meet its current demands, RC dental readiness must be transformed, and we have already made recommendations to achieve that transformation. I am proud to note the steady improvement in RC dental readiness over the last few years. I am confident that the Army will continue to address shortfalls in RC dental readiness with thoughtful solutions that will lead to continued improvement. Thank you for holding this hearing and inviting me to share my thoughts. Thank you for your continuing efforts in support of dental readiness, I look forward to your questions.

UNCLASSIFIED

RECORD COPY

STATEMENT BY

COLONEL DAVID SPROAT
CHIEF SURGEON OF THE ARMY NATIONAL GUARD
NATIONAL GUARD BUREAU

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

SECOND SESSION, 110TH CONGRESS

ON

DENTAL READINESS IN THE ARMY NATIONAL GUARD

April 23, 2008

NOT FOR PUBLIC DISSEMINATION
UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

Chairman Snyder, Ranking Member Aiken, as the Chief Surgeon of the Army National Guard, I am here today to answer your concerns about the dental readiness of Soldiers in the Army National Guard.

The interest of the subcommittee in this issue is well placed. Dental readiness of our Citizen-Soldiers is a critical element in their capability to meet Army requirements for deployment.

CURRENT SITUATION

The transition from a Strategic Reserve to an Operational Force has placed tremendous strain on the Army National Guard. Historically, as a strategic reserve, Soldiers and leaders of the Guard planned to have dental readiness issues addressed at the mobilization station. The implementation of the Department of Defense's 12 month mobilization policy in February 2007 has forced units to address dental readiness at home station in order to maximize collective training at the mobilization station.

The Army National Guard Medical Team, in conjunction with our US Army Dental Command colleagues, has successfully managed this transition to an Operational Force. Since the beginning of the fiscal year, the States have prepared five Brigade Combat Teams (BCT) for deployment; sending their units to MOB station over 90% dentally ready. For example, the 39th BCT from Arkansas arrived at Camp Shelby in January with 92% of their Soldiers dentally ready. This is a tremendous improvement from the last mobilization of the 39th BCT in October 2003, when the average readiness of a Guard unit reporting to the mobilization station was 13%. This significant decrease in the number of training days lost to dental treatment at mobilization station has enabled commanders to focus on collective training and maximized the boots-on-ground time in theater.

To ensure mission success, the same processes and techniques are being used this year by the 28th Combat Aviation Brigade and 56th Striker BCT from Pennsylvania, the 50th Infantry BCT from New Jersey, the 30th Heavy BCT from North Carolina, and 56th/36th Infantry BCT from Texas.

Due to the low level of baseline dental readiness in the National Guard – currently only 43% of the force is dentally ready to deploy - truly herculean efforts must be applied by the States once a unit is alerted. Dental activities compete for the time of leaders, Soldiers and Families as a unit prepares to go to war. Soldiers that are cross-leveled to a ready unit dilute that unit's readiness and lengthen training timelines.

In order to improve the baseline readiness of the Army National Guard, the same programs, policies and procedures that have been used to successfully ready these BCTs for deployment need to be applied to our force as a whole.

ACTIONS TAKEN

The Army National Guard, in conjunction with the Office of The Surgeon General, US Army Dental Command, and the US Army Reserve, has developed a multifaceted plan that has been approved by both the Army and National Guard leadership.

The cornerstone of this plan is the ability to provide dental treatment to our Soldiers outside of alert. The transition of the Army National Guard to an Operational Force has enabled the Army to provide dental treatment to Soldiers throughout the Army Force Generation (ARFORGEN) cycle. This will have the largest impact on the baseline readiness of the Guard.

The Army Selected Reserve Dental Readiness System (ASDRS) will enable States to provide dental treatment to Soldiers through local contracts or utilizing the Tri-Service Reserve Health Readiness Program (RHRP).

The National Guard is a reflection of the nation, and very few Army National Guardsmen have private dental insurance. The participation rate in the TRICARE Reserve Dental Program hovers at 7%. The ability to provide treatment to our Soldiers through the Army Selected Reserve Dental Readiness Program will have a tremendous impact on the readiness of the Guard.

This program will also enable the Army National Guard to maximize the benefits of US Army Dental Command's initiatives. The First Term Dental Readiness Program will provide examinations for our Soldiers and identify dental issues that must be corrected. If work cannot be completed at the training station, the ASDRS provides the ability to correct these issues when the Soldier returns to the State. Likewise, Soldiers who have issues that are identified at demobilization when examined by Active Component dentists can have their work completed when returned to their home state. We are conducting pilots of this process with BCTs redeploying to the states of South Carolina, Virginia and West Virginia.

With treatment programs in place, to ensure success we must also address barriers to compliance with readiness requirements. Active component Soldiers do not take unpaid leave to go to the dentist; nor should Guardsmen. The ability to provide two medical readiness days per Soldier would be a powerful incentive for the Soldier to complete readiness requirements, as well as a tool for our commanders to ensure compliance. It would further improve overall unit readiness by removing medical readiness as a competitor for training days.

Along with treatment and incentives, there must be enforcement as recommended by the Commission on the National Guard and Reserve. As alerted units prepare to go overseas, dental readiness is consistently the main reason for Soldiers being ineligible for the deployment. The Unit Status Report (USR), in conjunction with the Medical Protection System (MEDPROS), provides unit and senior leaders the capability to track a unit's progress as they prepare for deployment. Their extensive use by our BCTs and State leaders has enabled our recent successes. These tools must be applied and dental readiness enforced by leaders at all levels throughout the Guard to improve the readiness of all our Soldiers.

Lastly, in order to execute these programs and sustain an increase in the Dental readiness of the Guard, we must have the appropriate staffing. The Army National Guard Dental Corps is currently less than 60% strength, and the majority of remaining Dentists are retirement eligible. This committee is considering the Department of

Defense's request to increase the retirement age of National Guard medical corps and dental corps officers from age 64 to age 68. This would create the same standard for all three components. I would ask that this committee support that request and make that adjustment to the law. This will help to retain medical and dental professionals and capability in the Army National Guard.

Likewise, as a reserve component consisting largely of part-time warriors, the National Guard relies heavily on its cadre of full-time personnel to do the administration, maintenance and training preparation required to produce a ready force. The president's budget request now before Congress seeks an increase in the level of full-time manning in our force. This is critical. We urge the Congress to support this increase.

CONCLUSION

This is a very exciting time to be in the Guard. The Army National Guard has deployed over 300,000 dentally ready Soldiers in support of the Nation since September 11, 2001. Even so, we can do better. The Army and the Army National Guard are committed to our Citizen-Soldiers, by caring for them and improving their dental readiness.

I am grateful for this opportunity to appear before this subcommittee and look forward to answering your questions.

Not for Publication until released by
the House Armed Services Committee

Statement of

Captain Kerry J. Krause, DC, USN

Reserve Affairs Officer

Bureau of Medicine & Surgery

Before the

House Armed Services Committee

Subcommittee on Oversight and Investigations

Subject:

Dental Readiness in the Reserve Component

23 April 2008

The House Armed Services Committee

Chairman Snyder, distinguished members of the committee, good afternoon, and thank you for the opportunity to testify before you today about Navy Dentistry's mission -- that of ensuring dental readiness for all of its Sailors and Marines, both Reserve and Active.

Dental readiness is a state where a Sailor or Marine is ready to deploy and likely not to experience a dental emergency while away from home.

When a recruit is accessed, an initial exam is performed and he/she is classified according to his/her dental disease. Annual exams are required for both Reserve and Active Component Sailors and Marines. It is a triage system that prioritizes care based on their level of dental disease. A Sailor or Marine is Operationally Dental Ready (ODR) if he/she falls into either Class 1 (no disease) or Class 2 (disease not likely to cause a dental emergency within 12 months). The goal as stated by the Office of the Secretary of Defense for Health Affairs is for all services to reach 95% ODR. There is currently no Navy-specific mandate.

Over the past 3 years, incoming Navy and Marine Corps recruits have entered boot camp with an average ODR of 29%. At the Navy and Marine Corps' boot camps, Navy Dentistry has maintained a heavy dental presence that focuses on reaching the 95% goal before our recruits go back to Reserve status or reach their duty stations. While we have fallen short of the 95% goal in the last few years, we have maintained an ODR in the 80th percentile. Historically, through 2002, ODR percentage across the Navy has been in the mid 90s or above. Since 2002, however, it has fallen to 86-87% as we shift resources to focus on personnel who are getting ready to deploy.

For the Navy Reserve, of the 16,193 service members that are still drilling and have mobilized, they were 91% operationally dental ready with 1.5% being considered Class 3. For the Navy's active component, the last 112 ships that have deployed have all had an ODR above 95%.

Over the first quarter of FY08, the overall ODR for the Marines Corps Reserve was 77.7% with 6.5% being considered Class 3. Our efforts to focus on deploying Marine Reservists have paid off and the last two Battalions to deploy in 2007 went out at greater than 95% ODR. Active duty Marine units deployed at 90-97% ODR,

The Reserve challenges to ODR include dental officers and technicians retention and recruiting and the loss of 17% of the Reserve Dental Corps billets. As the Navy Reserve Dental Corps has become smaller, providing regular exams has become a challenge. We are meeting this challenge by using contract dentists, offering more incentives to retain and recruit, hosting "dental stand downs" for units to get exams all at one time, and having traveling dental teams go to remote locations. In addition, there is a perception by Reservists that the cost of the Tricare Dental Program – $11.58 per month with 20% cost-share for fillings – is prohibitive. We are addressing this issue by increasing our education efforts for Reservists on the value of the program.

To maintain our ODR goals with decreased Reserve and Active Dental Corps personnel, we have increased the use of Private Sector Dentists though the Military Medical Support Office program (MMSO). This shift in care to the private sector has increased the MMSO costs over the past four years from $3.7M in 2004 to $34M in 2007.

Retaining Dental Corps officers in Reserve and Active components has been increasingly difficult in recent years. Almost 70% of Junior Officers are leaving Active

Duty after they complete their first obligated tour and are not affiliating with the Active Reserve. One of the major issues has been dental assistant support, which is now beginning to improve. Another motivator for getting out of the service has been the rates of promotion and pay for Dental Corps officers. Promotion issues are improving, and we are hopeful that the trend will be maintained. In addition, recent improvements by the National Defense Authorization Act increased the Additional Special Pay (ASP) for junior dental officers by $6,000.00 to $10,000.00 or $12,000.00 based on years of service. We expect this increase in the ASP will have a positive impact on retention. Today, with this increased pay, an Active Duty general dentist in Washington DC, with 4 years experience, earns about $95,000 plus benefits.

Improvements to Dental Corps accession bonuses for Reserve and Active Duty and stipends for Reserve scholarship programs have recently improved and we thank you for your support. We are optimistic these enhancements have improved our recruitment efforts, as we at this point in the fiscal year expect to meet our accession goals. Currently we are almost 100% ahead of where we were last year at this time. In the Reserve Corps, we have already gained 14 new dental officers compared to 2 in all of fiscal year 2007.

Chairman Snyder, members of the committee, thank you again for the opportunity to testify before you and share with you how Navy Dentistry is ensuring sailors' and Marines' dental readiness remain a priority. We appreciate your efforts to improve our recruitment and retention, as well as your interest in this very important issue. I stand prepared to respond to any of your questions.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: Dental Readiness in the Reserve Component

STATEMENT OF: Colonel Deborah L. Hart, Mobilization Assistant to the Air Force Assistant Surgeon General for Dental Services

April 23, 2008

**NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES**

BIOGRAPHY

UNITED STATES AIR FORCE

Headquarters Air Reserve Personnel Center
Office of Public Affairs
Denver, CO 80280-1010

COLONEL DEBORAH L. HART

Colonel Deborah L. Hart is the mobilization assistant to the Assistant Surgeon General for Dental Services, Bolling Air Force Base in Washington D.C. She is a key advisor to the Assistant Surgeon General for Dental Services for developing plans, policies and standards that affect the Air Force Reserve Command Dental Service. She provides guidance in the training, force development, and personnel utilization of reserve dental forces in peacetime, as well as wartime.

Colonel Hart entered active duty in 1982, after earning her DMD degree from the University of Pittsburgh School of Dental Medicine, Pittsburgh, PA. She was accepted into the Air Force General Practice Residency in 1982 and graduated with distinction. From there she served at Williams Air Force Base, AZ until 1985 and became the first Air Force dentist to be assigned to NATO Air Base, Geilenkirchen, Germany until she separated from active duty in 1989. She was Chief of Dental Services, 106th ANG unit, Westhampton Beach, NY, IMA to Pease Air Force Base and Chief of Dental Services 910th Medical Squadron, Youngstown Air Reserve Base, OH. Prior to assuming her current position, she was commander of the 910th Medical Squadron, Youngstown Air Reserve Base, OH.

In her civilian life, she has been in private practice and a clinical instructor at Tufts Dental School in Boston, MA. She is currently a clinical professor at the University of Pittsburgh School of Dental Medicine, Pittsburgh, PA.

EDUCATION:

1976 Bachelor of Science degree in Biology, University of Pittsburgh, PA
1982 Doctor of Dental Medicine, University of Pittsburgh, PA
1983 General Practice Residency, Barksdale Air Force Base, LA
1984 Squadron Officer School, in residence
1987 Air Command and Staff College, by seminar
1999 Air War College, by correspondence

ASSIGNMENTS:

1. July 1982 – July 1983, General Practice Residency, Barksdale Air Force Base, LA
2. August 1983 –October 1985, General Dentist, Williams Air Force Base, AZ
3. November 1985- July 1989, Acting Base Dental Surgeon, Assistant Base Dental Surgeon, NATO Air Base Geilenkirchen, Germany
4. November 1989- October 1990, IMA to Pease Air Force Base, NH
5. November 1990- December 1992, Chief Dental Services, 106th Clinic, Air National Guard Base, Westhampton Beach, NY
6. January 1992 – October 2002, Chief of Dental Services, 910th Medical Squadron, Joint Air Reserv Base, Youngstown, OH
7. October 2002 - October 2004, Commander, 910th Medical Squadron, Joint Air Reserve Base, Youngstown, OH
8. November 2004 - present, mobilization assistant to the Assistant Surgeon General for Dental Services, Headquarters U.S. Air Force, Bolling Air Force Base, Washington D.C.

MAJOR AWARDS AND DECORATIONS:

Meritorious Service Medal with one device
Air Force Commendation Medal
Air Force Outstanding Unit Award
United States Coast Guard Unit Commendation with one device
National Defense Service Medal

OTHER ACHIEVEMENTS:

1984 - Company Grade Officer of the Quarter, Williams Air Force Base, AZ
1991 - Fellow of the Academy of General Dentistry
1991 - Outstanding Clinical Instructor Award, Tufts Dental School, Boston, MA
1999 - Superior Performance Award, Volk Field Exercise, Volk Air National Guard Base, WI

PROFESSIONAL MEMBERSHIPS AND AFFILIATIONS:

American Dental Association- member
Academy of General Dentistry- fellow
Reserve Officers Association- member
Association of Military Surgeons of the United States- member
Association of Air Force Reserve Flight Surgeons- member

EFFECTIVE DATES OF PROMOTION:

Second Lieutenant	NA
First Lieutenant	Feb 12 1982
Captain	June 18, 1982

Major	June 18 1988
Lieutenant Colonel	Oct 18, 1992
Colonel	June 1, 1999

(Current as of April 2008)

Mr. Chairman and esteemed members of the Committee, I appreciate the opportunity to appear before you today to discuss the dental readiness of the Air National Guard and Air Force Reserve. The ARC, or Air Reserve Component, Medical and Dental Services exist and operate within an Air Force culture of accountability where medics work directly for the line of the Air Force. Because we are committed to remain in the highest state of readiness, we align ourselves with our Chief of Staff's top priorities: Win Today's Fight, Take Care of our People, and Prepare for Tomorrow's Challenges.

Current State of Dental Readiness

Our home station facilities form the foundation from which the ARC provides combatant commanders a fit and healthy force. Our emphasis is on fitness, prevention, and surveillance so that we can be ready to deploy, if need be, in less than 72 hours.

Air Guard and Reserve dental readiness is at 89 percent and 86 percent, respectively. These statistics represent a steady upward trend over the past year and compare favorably to the Department of Defense goal of 95 percent. Our steadily improving dental readiness is attributable to many factors. First and foremost, is command emphasis and support at all levels. The ARC holds unit commanders and individual service members responsible for the member's readiness to deploy, and provides policies and processes to ensure readiness.

We have several methods for an ARC member to receive their annual dental exam: by a military dentist, civilian or TRICARE Dental Plan participating dentist, or by contractor dentists via the Reserve Health Readiness Program.

Although Medical Squadrons track dental readiness rates, each ARC unit also has a non-medical Unit Health Monitor who tracks upcoming and overdue medical and dental needs of the unit's members. This creates ownership of medical readiness within the unit itself, which has had an extremely positive effect on readiness.

ARC compliance policies may be the most effective of our tools to steadily improve readiness. Air Reservists or Guardsmen in Dental Class 3, requiring urgent or emergent dental treatment, are placed on a medical profile and cannot have orders cut to deploy while profiled. Members are given a limited time frame to correct their dental deficiencies. Failure to have the required treatment can lead from profiling to administrative discharge of the member. Commanders have the authority to grant a waiver to allow deployment of a member in Dental Class 3, but this is extremely rare.

All ARC units have regular Health Services Inspections and units with deficient programs are identified to line commanders, who are held accountable for the medical and dental readiness of their units.

Another tenet of our success has been the full alignment with the Active Duty Air Force Dental Service in using the same web-based IT reporting and tracking tool, the Dental Data System-web, or DDSw, for reporting and tracking dental readiness.

Challenges the Services Face to Improve Dental Readiness

Several challenges remain for the ARC to be able to steadily improve dental readiness. The cost of meeting standards can sometimes be prohibitive, especially for the lower ranking enlisted personnel. Even with the Tricare Dental Plan available, many areas in the US have limited networks of dental providers even if the Reservists and Guardsmen voluntarily purchase the insurance.

Furthermore, due to time constraints and the rigors of basic military training and technical school, access to new accessions for dental treatment is very limited and usually consists of palliative care for urgent or emergent needs. Currently, there is no Transitional Assistance Management Program (TAMP) available for dental care following deployment. And although the ARC and Active Duty Air Force use the same IT web based tracking and reporting tool to track readiness statistics, we are not yet set up to implement the electronic dental record (AHLTA), which will surely improve accuracy of dental readiness as Reservists and Guardsmen transition from inactive to active status and back again.

Actions Taken and Planned to Improve Dental Readiness

To improve dental readiness, Reserve and Guard units can utilize dentists from other units or Services for support. Higher headquarters monitors readiness statistics, conducts site visits, and provides assistance where needed. Geographically separated, remote, or understaffed units can utilize contractor supported dental exams. Increased emphasis by commanders, unit

health monitors, and recruiters to inform Reserve and Guard members of the benefits presently provided under the Reserve Health Readiness Program may also improve readiness rates.

We are also considering the introduction of a pre-accession dental screening exam to determine the dental class of the individual, which could help alleviate the problem of ARC members arriving on base as Dental Class 3, non-deployable personnel, after basic and technical training.

Lastly, we fully support implementing the electronic dental record in the ARC as it becomes available for deployment.

Conclusion

In closing, Mr. Chairman, we are proud of our accomplishments and continued improvement of the Air Force Reserve and Air National Guard Dental readiness rates. We thank you and the members of your subcommittee for your interest and support and look forward to your help in continuing that improvement.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

APRIL 23, 2008

QUESTIONS SUBMITTED BY DR. SNYDER

Dr. SNYDER. Is there anything you didn't have an opportunity to share during the hearing that would be valuable to the subcommittee's enquiry? Please provide the subcommittee with any further written testimony or data you think is relevant.

Colonel MARTIN. I would like to add a few comments regarding available dental programs that I covered in my written testimony. I believe these comments may be relevant to potential outcomes that may arise from this hearing.

In my written statement, with regard to deactivated Reserve Component members, I wrote, "If treatment is required, the member may apply for Department of Veterans Affairs (VA) treatment within 180 days of release from active duty. On average, about 18 percent of eligible deactivated reservists have utilized this benefit over the past three years."

Although the VA benefit was mentioned in my written testimony, it was not discussed further during the hearing. Outpatient dental benefits are provided by the VA, according to law. Per VA Health Care Fact Sheet 164–3, "Outpatient Dental Treatment," dated March 2008, it is noted that "Effective January 28, 2008, recently discharged veterans with a service-connected non-compensable dental condition or disability who served on active duty 90 days or more and who apply for VA dental care within 180 days of separation from active duty, may receive a one-time treatment for dental conditions, if the dental condition is shown to have existed at the time of discharge or release and the veteran's certificate of discharge does not indicate that the veteran received necessary dental care within a 90-day period prior to discharge or release." VA Health Care Fact Sheet 164–3 can be found at www.va.gov/healtheligibility/Library/pubs/Dental/Dental.pdf. Although underutilized, this is a current dental benefit available to many deactivated Reserve Component members. Increased utilization could have an effect on Reserve Component dental readiness.

In my written testimony, I also described the eligibility and enrollment of Reserve Component members in the TRICARE Dental Program (TDP). The TDP is a program that allows Reserve Component members to maintain continuity of dental care in both pre-activated and deactivated status. Unfortunately, Reserve Component enrollment is very low. Service feedback has indicated that enrollee cost shares may have an effect on the low enrollment of Reserve Component members.

Dr. SNYDER. Is there anything you didn't have an opportunity to share during the hearing that would be valuable to the subcommittee's enquiry? Please provide the subcommittee with any further written testimony or data you think is relevant.

Colonel BODENHEIM. During the testimony, I did not have the opportunity to clarify the career cycle of an Army Reserve Components (RC) Soldier and outline the ideal associated dental readiness maintenance system required to achieve an operationalized, dentally fit Army RC which minimizes "just in time" dentistry at the mobilization platform, poor dental health of cross leveled Soldiers and the subsequent loss of training time that I outlined during my testimony. Dental disease is not a fixed health condition such as an appendix, which upon infection, requires removal one time for a successful health outcome, but is a persistent disease process requiring a continuum of care in order to reach a consistent baseline of successful deployment dental readiness. As an example of the persistent nature of dental disease, the 1/34th BCT from Minnesota was deployed from Camp Shelby, MS at a 100% dental readiness status [Dental Fitness Class (DFC) 1 and 2] but demobilized at Ft. McCoy with a DFC 3 rate of over 9%.

Each RC Soldier enters the Army through Initial Entry Training (IET) which consists of a combination of Basic Combat Training followed by Advanced Individual Training (AIT). Some RC Soldiers complete both their Basic and AIT training consecutively, but significant percentages complete their training using a split training option over a two year period. RC Soldiers are not considered deployable until they have completed both parts of their training. During IET, the Army Dental Care System (ADCS), under the operational command of the U.S. Army Dental Command (DENCOM), examines and treats IET Soldiers (both AC and RC) within the First Term Dental Readiness (FTDR) program. The future goal (FY 2011) is to return Soldiers to their units in a 95% DFC 1 or DFC 2 status upon completion of their IET.

After IET, RC Soldiers return to their unit and are integrated into the Army Force Generation (ARFORGEN) process. The ARFORGEN process is used to manage the force and ensure the ability to support demands for Army forces. The Army Selected Reserve (SELRES) goal is to maintain dental readiness at the 95% DFC 1 or DFC 2 level within the ARFORGEN cycle and outside of alert for mobilization, by using the Army SELRES Dental Readiness System (ASDRS) which provides the policy authorization for RC unit commanders to maintain the dental readiness (annual exams and DFC 3 treatment) of their Soldiers through the Reserve Health Readiness Program (RHRP), a DOD contracted medical/dental readiness provider network, Army National Guard (ARNG) direct contracts, or RC military dental personnel.

Upon mobilization alert, units improve their dental readiness, currently averaging approximately 73%, by using the same contracted entities in the ASDRS program under contingency operations. Upon mobilization, the ADCS validates the dental readiness of mobilized RC Soldiers at the mobilization station, determines their GO (DFC 1 or 2) or NO GO (DFC 3 or 4) status and deploys them at 100% GO status. The RC Soldier is deployed and receives necessary theatre care from deployed dental assets to sustain the fight. Upon re-deployment, the RC Soldier demobilizes and receives a dental examination within the ADCS (mission to be initiated in July 2008). DFC 3 conditions identified during the examination and which cannot be treated during the short 4–6 day demobilization timeline are documented on a voucher system. The Soldier returns to his/her unit and their voucher is managed under the contracted entities of the ASDRS to complete DFC 3 treatment. The ARFORGEN and associated dental readiness maintenance cycle of the Soldier is completed. Throughout the cycle, the RC Soldier's dental readiness radiographic and exam data will be captured and archived into the Army Dental Digital Repository (ADDR) as well as the RC electronic exam record and tracking system, DENCLASS. These electronic systems will be synchronized during the summer of 2008 and will reduce the duplication of processes and resources throughout the RC dental readiness maintenance cycle.

Each consecutive phase of the dental readiness cycle depends upon the previous phase's success in implementing its dental readiness mission. Phases that are not implemented or poorly implemented reduce the effectiveness of the previous phase due to the chronic nature of dental disease because dental treatment increases in complexity and cost in direct proportion to the amount of time the dental condition remains untreated. Operationalization of the RC force should ideally include a continuous dental readiness maintenance program throughout the career cycle of the Soldier.

Dr. SNYDER. Please provide an update of the Army's progress toward implementing a plan to address low dental readiness rates. Please provide documentation of decisions and implementation plans.

Colonel BODENHEIM. On May 27, 2008, the Army Chief of Staff approved a plan to address RC Soldiers' dental examinations and readiness care through the Defense Health Program (DHP) during period in which the Soldiers' duty status entitles them to active duty dental care. In addition to the period of active duty dental care while the Soldier is at the mobilization platform, these periods will mainly occur during Initial Entry Training through the First Term Dental Readiness (FTDR) program and through the Dental Demobilization Reset (DDR) at demobilization sites. In anticipation of a MEDCOM Operational Order (OPORD) directing the DDR mission, the DENCOM:

1. Initiated a warning order during a 4 June VTC to its Regional Dental Commanders.

2. Is prepared to create and issue a DENCOM OPORD upon receipt of the MEDCOM OPORD.

3. Is prepared to create an All Army Activities (ALARACT) to be staffed in order to coordinate support with other Army commands.

4. Briefed a Contingency Operation Plan on 4 June, to the Deputy Surgeon General outlining general DDR operational plans and FTDR general plans.

5. Chief of Information Management is identifying IM/IT equipment requirements.

6. Chief of RC Mobilization/Demobilization Operations and the Special Staff to the Assistant Surgeon General (Force Projection) Lean Six Sigma Certified Black Belt jointly identified on 5 June the detailed patient and digital information DDR processing flow requirements. This includes the creation of a digital voucher that can be transferred to the ASDRS. The DENCOM Chief of Informa-

tion Management was briefed on the digital information requirements and began work on those requirements.

7. Is initiating Dental equipment purchases. As examples, equipment is being ordered for the new Camp Shelby SRP dental station and the new Camp Atterbury dental clinic.

The Army SELRES Dental Readiness System (ASDRS) will focus resources on RC Soldiers most likely to be mobilized and called to active duty. Elements of the ASDRS program can also be employed to address dental readiness needs identified during the DDR examination. The Army National Guard is currently conducting demonstration projects to evaluate the effect of the ASDRS program on training and readiness. The United States Army Reserve, through a dental Ready Response Reserve Unit (R3U) pilot program, will perform a pre-mobilization dental readiness mission in late July. The Army is addressing RC dental readiness through multiple approaches using AC and RC dental personnel as well as contracted solutions.

Dr. SNYDER. Is there anything you didn't have an opportunity to share during the hearing that would be valuable to the subcommittee's enquiry? Please provide the subcommittee with any further written testimony or data you think is relevant.

Colonel HART. I have nothing further to add to the previously submitted testimony.

Dr. SNYDER. Is there anything you didn't have an opportunity to share during the hearing that would be valuable to the subcommittee's enquiry? Please provide the subcommittee with any further written testimony or data you think is relevant.

Captain KRAUSE. Retention of Active Duty (AD) and Reserve Component (RC) dentists has become an increasing concern. 70% of all dentists leave AD between three and six years with most choosing not to join the Reserves, which has also contributed to the Reserve shortages.

In FY07, the direct care dentist manpower (AD, Government Schedule and contract) dropped to approximately 1160. Even with the increased utilization of the Military Medical Support Office (MMSO), Operational Dental Readiness (ODR) could not be maintained at our goal of 95%. ODR is currently at 89%.

The 220+ RC dental officers when on two week Annual Training (AT) orders primarily work at the recruiting centers assisting the AD force. The reduced Reserve Dental Force size has resulted in decreased ability to provide AT and Active Duty for Special Work (ADSW) surge support to AD dental treatment facilities at Great Lakes, Marine Corps Recruit Depot (MCRD) SD, MCRD Parris Island, and Marine Corps Bases (MCBs) Camps Pendleton and Lejeune. On drilling weekends, RC dentists primarily do examinations on reserve units to help identify dental work the reservists need to obtain (offered through the Tricare Dental Plan (TDP)).

In the FY08 NDAA, Congress prohibited further medical and dental conversions. Currently, Navy Medicine plans to restore approximately 130 active duty dental officers and over 500 assistant billets from FY10–13. This should help improve direct care treatment. Recruitment for AD and RC is improving considerably with increased bonuses and retention is also expected to improve.

Reserve Dental Officers have Navy training, knowledge, and experience. They can provide accurate, cost effective, quality dental support to the Active and Reserve Force. To meet the dental support requirements of the Navy the size of the RC Dental Force would also need to be increased.

Dr. SNYDER. Is there anything you didn't have an opportunity to share during the hearing that would be valuable to the subcommittee's enquiry? Please provide the subcommittee with any further written testimony or data you think is relevant.

Colonel SPROAT. Thank you for the opportunity to appear before the Committee and present the views of the Army National Guard. I believe my written and oral testimony adequately addressed the needs and concerns of the Army National Guard.

○